DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

MAR 26 2012

Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Avenue, 6th Floor, MS 0000
Sacramento, CA 95814

Dear Mr. Douglas:

I am pleased to inform you that your request to renew California's Section 1915(c) Home and Community-Based Services (HCBS) Waiver serving Individuals with Intellectual and Developmental Disabilities (ID/DD) has been approved. The Centers for Medicare & Medicaid Services (CMS) approves the renewal with an effective date of March 29, 2012. The State is adding Financial Management Services (FMS) as an approved waiver service with this renewal.

The following estimates of unduplicated participants and average per capita costs are approved:

	Unduplicated Recipients *(Factor C)*	Community Costs *(Factor D+D')*	Institutional Costs *(Factor G+G')*	Total Waiver Costs *(Factor C x Factor D)*
Year 1	100,000	$40,046.13	$66,929.00	$2,538,313,000
Year 2	105,000	$40,340.77	$63,415.00	$2,665,295,850
Year 3	110,000	$40,641.35	$62,640.00	$2,792,278,500
Year 4	115,000	$40,948.87	$61,895.00	$2,919,260,050
Year 5	120,000	$41,261.35	$61,405.00	$3,046,242,000

If the State wishes to modify the waiver program, an amendment request may be submitted to CMS via the HCBS web-based application portal. The waiver may be renewed at the conclusion of the five-year approval period providing the State shows documentation of satisfactory performance and oversight.

We very much appreciate the responsiveness of the Department of Health Care Services and Department of Developmental Services staff during the renewal of this HCBS waiver program. If you have any questions regarding the waiver, please contact Cynthia Nanes at (415) 744-2977 or by email at Cynthia.Nanes@cms.hhs.gov.

Sincerely,

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Dina Kokkos-Gonzales, Department of Health Care Services
Terri Delgado, Department of Developmental Services
Jim Knight, Department of Developmental Services
Alexandra Smilow, Centers for Medicaid and Medicare Services

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
The use of the 3.5 Waiver template results in some specificity not required in the previous Waiver application. Use of a co-employer service was available in the prior Waiver for specified service(s). The CMS mandated 3.5 template calls out very clearly the inclusion of FMS services in the renewal and the mandatory use of such by Waiver beneficiaries receiving voucher (participant directed) services.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **California** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
HCBS Waiver for Californians with Developmental Disabilities

C. Type of Request: renewal

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ○ **5 years**

☐ **Migration Waiver** - this is an existing approved waiver

☑ **Renewal of Waiver:**

Provide the information about the original waiver being renewed

Base Waiver Number: 0336

Amendment Number (if applicable):

Effective Date: *(mm/dd/yy)* 10/01/06

Waiver Number: CA.0336.R03.00
Draft ID: CA.14.03.00

Renewal Number: 03

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date: *(mm/dd/yy)*

03/29/12

Approved Effective Date: 03/29/12

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

This waiver will serve individuals who, in the absence of this waiver, would require care in either an intermediate care facility for the developmentally disabled (ICF/DD), ICF/DD-H (habilitative) or ICF/DD-N (nursing.)

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
California's HCBS DD Waiver offers community-based services not otherwise available through a participant's Medicaid program. The purpose of the HCBS DD Waiver is to serve participants in their own homes and communities as an alternative to placing Medicaid-eligible individuals in hospitals, nursing facilities or intermediate care facilities for persons with mental retardation. The HCBS DD Waiver program recognizes that many individuals at risk of being placed in these facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

Community-based services for individuals with developmental disabilities are provided through a statewide system of 21 private, non-profit corporations known as regional centers. Regional centers, as established by the Lanterman Developmental Disabilities Services Act, provide fixed points of contact in the community for persons with developmental disabilities and their families. Regional centers coordinate and/or provide community-based services to eligible individuals. The regional centers are community-based nonprofit corporations governed by volunteer Boards of Directors that include individuals with developmental disabilities, their families, a representative of the vendor community, and other defined community representatives.

Regional centers are funded through contracts with the Department of Developmental Services (DDS). They are responsible for the provision of outreach; intake, assessment, evaluation and diagnostic services; and case management/service coordination for persons with developmental disabilities and persons who are at risk of becoming developmentally disabled. In addition, regional centers are responsible for developing, maintaining, monitoring and funding a wide range of services and supports to implement the plans of care [or individual program plans (IPP)] for consumers. The IPPs are developed using a person-centered planning approach. Regional centers also conduct quality assurance activities in the community, and maintain and monitor a wide array of qualified service providers.

Regional centers are responsible for ensuring that eligible consumers who want to participate on the Waiver are enrolled, service providers meet the qualifications for providing Waiver services, IPPs are developed and monitored, consumer health and welfare is addressed and monitored, and financial accountability is assured.

DDS ensures, under the oversight of the Department of Health Care Services, the State Medicaid agency, that the HCBS Waiver is implemented by regional centers in accordance with Medicaid law and the State's approved Waiver application. The HCBS Waiver affords California the flexibility to develop and implement creative, community alternatives to institutions. California's HCBS Waiver services are available to regional center consumers who are Medicaid (Medi-Cal in California) eligible and meet the level of-care requirements for an intermediate care facility serving individuals with developmental disabilities.

California's first Home and Community-based Services Waiver for Californians with developmental disabilities was approved effective July 1982 with a total enrollment cap of 3,360. This Waiver application seeks to enroll up to 120,000 individuals in the federal fiscal year ending September 30, 2016.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals

under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The Department recently undertook a significant effort and process to ensure full input from consumers, family members, advocates, service providers, regional centers and the community, on the service delivery system at large and the Department's budget. The Department conducted a total of 16 stakeholder meetings with 8 subject matter focused workgroups comprised of consumers, family members, service providers, and representatives from statewide advocacy organizations, service provider organizations and regional centers. Three public hearings were also held. A conference call was also conducted with representatives from the Association of Regional Center Chief Counselors' Group. Input received through this broad public process was instrumental in the development of the Waiver renewal.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Kokkos-Gonzales

First Name: Dina

Title: Branch Manager

Agency: Department of Health Care Services

Address: 1501 Capitol Avenue

Address 2: P.O. Box 997413, MS 0000

City:

State: Sacramento

Zip: **California**

Phone: 95899-7413

Fax: (916) 552-9422 **Ext:** ☐ **TTY**

E-mail: (916) 552-9600

dina.kokkos@dhcs.ca.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: La Grandeur

First Name: Michelle

Title: Chief, Federal Programs Operations Section

Agency: Department of Developmental Services

Address: 1600 Ninth Street, Room 310

Address 2: MS 3-9

City: Sacramento

State: **California**

Zip: 95814

Phone: (916) 653-0960 **Ext:** ☐ **TTY**

Fax: (916) 654-3256

E-mail: michelle.lagrandeur@dds.ca.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid

agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Toby Douglas

State Medicaid Director or Designee

Submission Date: Mar 21, 2012

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Douglas

First Name: Toby

Title: Director

Agency: Department of Health Care Services

Address: 1501 Capitol Avenue, Suite 6086

Address 2: P. O. Box 997413 MS 4000

City: Sacramento

State: **California**

Zip: 95899-7413

Phone: (916) 440-7400 **Ext:** ☐ **TTY**

Fax: (916) 440-7404

E-mail: Toby.Douglas@dhcs.ca.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   (Complete item A-2-a).

   ◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:
   California Department of Developmental Services

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver

operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
The Department of Health Care Services (DHCS) is the California Medicaid Agency. DHCS has established an Interagency Agreement (IA) with the Department of Developmental Services (DDS), as the Organized Health Care Delivery System to administer the HCBS Waiver for persons with developmental disabilities (2006-2011) and the current waiver renewal request (control #0336; October 2011-September 2016).

The IA specifies the functions to be performed by both DHCS and DDS to ensure the administration of the waiver; the cost allocation plan; and the transfer of federal funds to DDS. The IA additionally specifies the oversight activities of DHCS, as well as billing and payment responsibilities of DHCS and DDS. The IA is reviewed and updated annually.

DHCS exercises administrative oversight, on an ongoing and/or as-needed basis (unless otherwise specified), in the administration and supervision of the Waiver and reviews the performance of DDS in operating the Waiver as follows:
1. Reviews and approves Waiver manuals, program advisories, technical letters and any other policies, procedures, rules or regulations that DHCS may identify as specific to the Waiver.
2. Ensures the technical compliance and correctness of the IA between DHCS and DDS and any subsequent related subcontracts.
3. Prepares required annual Waiver reports, i.e., CMS 372.
4. Reviews, negotiates and approves amendment requests for the IA.
5. Develops documents and guidelines that are used for monitoring fiscal and programmatic elements of the IA.
6. Coordinates with DDS in the administration of the Waiver Biennial Monitoring Protocol. The Protocol specifies the performance monitoring, analysis and evaluation of the regional centers. The on-site monitoring reviews are conducted jointly by DHCS and DDS.
7. Monitors DDS follow-up to ensure that areas of non-compliance discovered during monitoring reviews of the regional centers are remediated.
8. Conducts follow-up reviews with DDS as necessary, to determine if the areas of non-compliance have been corrected. The scope of the follow-up review is based upon the nature and extent of the areas of non-compliance.
9. Retains the authority to conduct independent focused reviews (announced and unannounced) to investigate DDS follow-up on significant special incident reports. Selection criteria may include, but is not limited to, severity of the event, unusual nature of circumstances, participant/advocate complaints or Centers for Medicare & Medicaid Services (CMS) concerns/requests for investigation.
10. Retains the authority to initiate a full-scope monitoring review in addition to routine monitoring reviews when: (a) there is a failure of fiscal audit; (b) there is a lack of response to a corrective action plan; (c) in the course of a monitoring review, DHCS or DDS needs assistance from other departmental branches; or (d) DHCS elects to conduct a full scale review based on evidence of inadequate case management and or poor fiscal management by regional center.
11. Exercise oversight of Waiver operations by quarterly reviewing the performance data compiled through the Waiver QMS. Through the Quality Management Executive Committee, DHCS collaborates with DDS in setting priorities for the Waiver quality improvement, in developing, implementing and monitoring remedial (system improvement) strategies; evaluating the effectiveness of interventions; and evaluating the effectiveness of the Waiver QMS.
12. DHCS exercises ongoing financial administration of the Waiver as follows:
a. Monitors DDS compliance with fiscal provisions specified in the IA regarding audits of regional center.
b. Reviews DDS audit protocol to ensure compliance with the Waiver and to ensure that DDS audits of regional centers are performed in accordance with established protocols and meet Generally Accepted Governmental Auditing Standards (GAGAS) requirements.
c. Reviews DDS regional center audit working papers on a sample basis and attends entrance and exit conferences of selected regional center audits.
d. DHCS reviews DDS audits of regional centers. These audits are designed to “wrap around” the independent CPA audit to ensure comprehensive financial accountability.
e. DHCS reviews DDS fiscal reviews of service providers and vendors as specified in the Waiver and the IA.
f. Refer and follow up on any program integrity issues that are identified as a result of oversight activities to DHCS Medi-Cal Operations Division, DDS for follow up, DDS Audits and DHCS Medi-Cal Policy Division for information.
g. Issues an annual report to the DHCS director and to CMS that summarizes oversight functions performed. A copy of the annual report is submitted to the DDS Director.

A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

   ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ○ **Not applicable**

   ◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

   ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

   Specify the nature of these agencies and complete items A-5 and A-6:

   ☑ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

   Specify the nature of these entities and complete items A-5 and A-6:

   Community-based services for individuals with developmental disabilities are provided through a statewide system of 21 private, non-profit corporations known as regional centers. Regional centers, as established by the Lanterman Developmental Disabilities Services Act, provide fixed points of contact in the community for persons with developmental disabilities and their families. Regional centers coordinate and/or provide community-based services to eligible individuals. The regional centers are community-based nonprofit corporations governed by volunteer Boards of Directors that include individuals with developmental disabilities, their families, a representative of the vendor community, and other defined community representatives.

   Regional centers are funded through contracts with the Department of Developmental Services (DDS). They are responsible for the provision of outreach; intake, assessment, evaluation and diagnostic services; and case management/service coordination for persons with developmental disabilities and persons who are at risk of becoming developmentally disabled. In addition, regional centers are responsible for developing, maintaining, monitoring and funding a wide range of services and supports to implement the plans of care [or individual program plans (IPP)] for consumers. The IPPs are developed

using a person-centered planning approach. Regional centers also conduct quality assurance activities in the community, and maintain and monitor a wide array of qualified service providers.

Regional centers are responsible for ensuring that eligible consumers who want to participate on the Waiver are enrolled, service providers meet the qualifications for providing Waiver services, individual program plans are developed and monitored, consumer health and welfare is addressed and monitored, and financial accountability is assured.

The vendorization process is the process for identification, selection, and utilization of service providers based on the qualifications and other requirements necessary in order to provide services. The vendorization process allows regional centers to verify, prior to the provision of services to individuals, that a provider applicant meets all of the requirements and standards specified in regulations.

The regional center is responsible for ensuring that the applicant meets licensing, certification, education, staffing and other Title 17 requirements for vendorization and approving vendorization based upon their review of the documentation submitted by the applicant.

DDS ensures, under the oversight of the Department of Health Care Services, the State Medicaid agency, that the HCBS Waiver is implemented by regional centers in accordance with Medicaid law and the State's approved Waiver application. The HCBS Waiver affords California the flexibility to develop and implement creative, community alternatives to institutions. California's HCBS Waiver services are available to regional center consumers who are Medicaid (Medi-Cal in California) eligible and meet the level of-care requirements for an intermediate care facility serving individuals with developmental disabilities.

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5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
It is DDS' responsibility to ensure, with the oversight of DHCS, that the waiver is implemented by regional centers in accordance with Medicaid statute and regulation.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
DHCS and DDS perform operational oversight and monitoring of regional center DD Waiver operational performance through fiscal audits and program policy compliance. When taken together, the oversight and monitoring methods test all six assurances.

   Audits and Financial Accountability:
   DDS performs fiscal audits of each regional center no less than every two years, and completes follow-up reviews of each regional center in alternate years. DDS will continue to require regional centers to contract with independent auditors to conduct an annual audit. The DDS audit is designed to "wrap around" the required independent CPA audit to ensure comprehensive financial accountability.

   DDS coordinates its activities with DHCS Audits and Investigations, who review DDS' audit reports of the regional centers on an ongoing basis.

   Program Policy Compliance
   • The State's Biennial Collaborative on-site HCBS' Waiver Monitoring review team includes DHCS and DDS staff with specific duties assigned to prevent duplication of effort by the two departments.
   o The review cycle is conducted every two years.
   o The two-year review cycle consists of a statistically valid, stratified, statewide sample of 1,050 Waiver participants selected at random from three major residence types: 1) Own Home-Parent; 2) Community Care Facility; and, 3) Independent Living or Supported Living. The size of the sample for each regional center varies depending on each

regional center's percentage of the statewide total of Waiver participants within each residence type.

o The face-to-face visits include interviews with the consumer and his/her family or significant others, involved direct support professionals and on-site observation of programs.
o Ten consumers who had reportable special incidents during the review period are selected for a review of their records to assess the extent to which identified problems or issues were addressed in a timely and appropriate manner to continuously assure the health and safety of participants.
o DDS may, at its own discretion, or in response to a complaint, do unannounced visits to a regional center or a provider.

Program Policy Follow-up Compliance Reviews.
As needed, during the off-year cycle of the two-year reviews, DHCS and DDS conduct follow-up monitoring and compliance reviews at the regional centers. This follow-up review focuses on the areas requiring implementation of a corrective action plan as identified by the previous compliance review, and progress in areas where changes were recommended. DHCS and DDS provide on-going training and technical assistance as needed during the review process. The training and technical assistance covers, at a minimum, all aspects of the waiver program, and is designed to address the needs of administrators, case managers, and clinicians. Because the training and technical assistance is tailored to each individual regional center's needs and is delivered on-site, it affords maximum opportunity to follow-up on issues identified in the compliance reviews.

Quality Assurance
DHCS and DDS jointly oversee the overall design and operation of a quality assurance program which allows it to continually plan, assess, assure, and improve the quality and effectiveness of services and the level of satisfaction of consumers. The system is outcome-based, focusing primarily on its customers, but also on its services and operations. The following are the key components of the State's quality assurance system:
• Through the planning team, development and periodic review (at least annually) of an individualized program plan for each consumer that addresses his or her health, living, and support needs.
• For licensed community care facilities, annual licensing evaluations by the Department of Social Services.
• Quarterly monitoring visits by the regional center for each person living in licensed community care facilities or receiving services from supported living or family home agencies.
• Enhanced case management (at a minimum, face to face monitoring every 30 days for the first 90 days after transition to the community) for individuals moving from developmental centers to community living arrangements.
• Daily, DDS and regional center review and follow-up on special incidents.
• Annual review by the regional centers of each community residential care facility to assure services are consistent with the program design and applicable laws, and development and implementation of corrective action plans as needed.
• On an ongoing basis, review and investigation of health and safety complaints by protective services agencies, area boards, Disability Rights California, DDS, regional centers, licensing agencies, and/or law enforcement agencies.
• On an ongoing basis and at a minimum, quarterly, training and technical assistance provided by the Department and regional centers to enhance service quality.
• Contracts with Disability Rights California to provide ongoing clients' rights advocacy services to individuals with developmental disabilities residing in the community.
• On an annual basis, DDS issues a report card to each center on Performance Contract outcomes. Each regional center is required to share these results with their community. DDS takes follow-up action as appropriate when decreases in the desired measures are noted.
• On an ongoing basis, DDS collects information about the fair hearing process including type(s) of services in dispute, the resolution of the appeals, and at what level (informal, mediation or state level) the appeal was resolved. DDS disseminates semi-annual reports to regional centers, and reviews the data for anomalies or irregularities with fair hearing filings, and monitors as needed.

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7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid

Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Other State Operating Agency	Local Non-State Entity
Participant waiver enrollment	☑	☑	☑
Waiver enrollment managed against approved limits	☑	☑	☑
Waiver expenditures managed against approved levels	☑	☑	☐
Level of care evaluation	☑	☐	☑
Review of Participant service plans	☑	☑	☑
Prior authorization of waiver services	☐	☐	☑
Utilization management	☐	☑	☑
Qualified provider enrollment	☑	☑	☑
Execution of Medicaid provider agreements	☑	☑	☑
Establishment of a statewide rate methodology	☐	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑	☐
Quality assurance and quality improvement activities	☑	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of HCBS Waiver Monitoring Protocols, policies and procedures reviewed by the Medicaid Agency found to be compliant. Numerator = number of HCBS Waiver monitoring Protocols, policies and procedures reviewed by the Medicaid Agency that are found to be compliant. Denominator = total number of HCBS Waiver monitoring protocols, policies and procedures reviewed by the Medicaid Agency

Data Source (Select one):
Other
If 'Other' is selected, specify:
Periodic policy updates, monthly invoices, waiver applications/ amendments.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Number and percent of consumer IPPs developed in accordance with State policies and procedures. Numerator = number of consumer IPPs developed in accordance with State policies and procedures. Denominator = total number of IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Representative Sample; Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC)	

	every two years. Focused follow-up reviews are conducted annually or more frequently as needed.

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of Medicaid Agency review of HCBS Quarterly waiver reports completed by DDS. Numerator = number of HCBS Quarterly waiver reports completed by DDS which were reviewed by Medicaid Agency. Denominator = total number of HCBS Quarterly waiver reports generated by DDS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Quarterly waiver reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified**

		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of required coordination meetings conducted between the Medicaid Agency, DDS and DSS (As required). Numerator = number of coordination meetings conducted. Denominator = total number of planned coordination meetings.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Coordination meetings conducted between the Medicaid Agency, DDS and DSS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: At least quarterly	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of required oversight/monitoring meetings conducted between DDS and the Medicaid agency. Numerator = number of oversight meetings conducted. Denominator = number of planned oversight meetings.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Oversight/monitoring meetings conducted between DDS and Medicaid Agency

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: At least quarterly	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of DDS Quality Management Executive Committee (QMEC) Meetings conducted. Numerator = number of QMEC Meetings Conducted. Denominator = total number of planned Quality Management Executive Committee Meetings.

Data Source (Select one):
Other
If 'Other' is selected, specify:
QMEC Meetings

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: At least semi-annually.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
	At least semi-annually.

Performance Measure:
Number and percent of funds identified in DDS fiscal audits for repayment that were recovered. Numerator = dollar amount of funds identified for repayment by DDS audits that were recovered. Denominator = total dollar amount identified for recovery.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Fiscal Audits

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of HCBS Quarterly waiver reports issued that ensures enrollment is managed against the approved limits. Numerator = number of HCBS Quarterly waiver reports issued that ensures enrollment is managed against the approved waiver limit. Denominator = total number of HCBS Quarterly waiver reports issued.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HCBS Quarterly Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Number and percent of DDS invoices tracked to ensure expenditures are managed against approved limits. Numerator = number of DDS invoices tracked to ensure expenditures are managed against approved limits. Denominator = total number of invoices submitted by DDS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Invoices

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of new enrollees who had a LOC determination prior to waiver enrollment. Numerator = number of consumer records reviewed of new enrollees that documented an initial LOC determination prior to waiver enrollment. Denominator = total number of new enrollee consumer records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Representative Sample; Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in

		each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of level-of-care (LOC) determinations that were done utilizing the process outlined in the approved waiver. Numerator = number of consumer records reviewed that documented LOC determinations utilizing the process outlined in the approved waiver. Denominator = total number of consumer records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Representative Sample; Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When individual problems are discovered, DDS, with oversight from DHCS, works with the regional centers to resolve the problem. For example, individual issues identified during the State's Biennial Collaborative on -site HCBS Waiver Monitoring Reviews are documented in monitoring reports which are sent to the regional centers with the State's recommendations for resolution. Depending on the situation, resolution may require further site visits from the regional center or the Department of Social Services. The regional center's plans for correction submitted in response to the State's recommendations are evaluated and approved by DHCS and DDS before the final monitoring report is issued to the regional center and forwarded to CMS. Individual problems identified through the other discovery methods identified above and elsewhere in this application are addressed in a similar fashion. Documentation of individual issues and resolution is maintained and aggregated by DDS and allows for system wide analysis by the Quality Management Executive Committee.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Regional Centers	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
( ) **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
( ) **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
(●) **Mental Retardation or Developmental Disability, or Both**					
	☑	**Autism**	0		☑
	☑	**Developmental Disability**	0		☑
	☑	**Mental Retardation**	0		☑
( ) **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The State further specifies its target group(s) as follows:

• California uses the State's definition of "developmentally disabled" and "substantial disability" for the target population of this waiver, as defined in the California Lanterman Developmental Disabilities Services Act, Welfare

and Institutions Code, §4512, as follows:

"Developmental disability" means a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include disabling conditions found to be closely related to mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

"Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:
(1) Self-care.
(2) Receptive and expressive language.
(3) Learning.
(4) Mobility.
(5) Self-direction.
(6) Capacity for independent living.
(7) Economic self-sufficiency.

• Regional center consumers who are Medi-Cal beneficiaries who meet the level of care for this waiver.

• Consumers shall only be enrolled in one Section1915(c) waiver at any one time.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- (○) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (○) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

- ( ) **A level higher than 100% of the institutional average.**

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- ☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	100000
Year 2	105000
Year 3	110000
Year 4	115000
Year 5	120000

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- **Not applicable. The state does not reserve capacity.**
- **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- **The waiver is not subject to a phase-in or a phase-out schedule.**
- **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- **Waiver capacity is allocated/managed on a statewide basis.**
- **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

All individuals who express an interest and are eligible for enrollment are enrolled in the DD Waiver.

California will submit necessary DD Waiver amendments to accommodate all individuals who are eligible for and express an interest in participating in the DD Waiver should the approved DD Waiver capacity be insufficient to accommodate all interested persons.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (•) **No**
   - ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [x] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ( ) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

    Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

  All other mandatory and optional groups covered under the plan are included.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- **A special income level equal to:**

Select one:

- **300% of the SSI Federal Benefit Rate (FBR)**
- **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- **A dollar amount which is lower than 300%.**

Specify dollar amount:

- **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- **Aged and disabled individuals who have income at:**

Select one:

- **100% of FPL**
- **% of FPL, which is lower than 100%.**

Specify percentage amount:

- **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of

the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- (●) **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - (●) **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-b (SSI State) and Item B-5-d)
  - ( ) **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- ( ) **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ( ) **The following standard included under the State plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional State supplement standard**
  - ( ) **Medically needy income standard**
  - ( ) **The special income level for institutionalized persons**

    (*select one*):

    - ( ) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify the percentage: [ ]
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage: [ ]
  - ( ) **Other standard included under the State Plan**

    Specify:

- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.

- **The following formula is used to determine the needs allowance:**

  Specify:

  The maximum amount of income to be eligible under the DD Waiver, including any income disregards or exemptions.

- **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- **Not Applicable**
- **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

  Specify:

  Specify the amount of the allowance (*select one*):

  - **SSI standard**
  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The following dollar amount:**

    Specify dollar amount: If this amount changes, this item will be revised.

  - **The amount is determined using the following formula:**

    Specify:

iii. Allowance for the family (*select one*):

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions) *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

The State does not establish reasonable limits.

The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

SSI standard

Optional State supplement standard

- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

  Specify percentage:
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- **The following formula is used to determine the needs allowance:**

  Specify formula:
- **Other**

  Specify:

  The maximum amount of income to be eligible under the DD Waiver, including any income disregards or exemptions.

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- **Allowance is the same**
- **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

   i. **Minimum number of services.**

   The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

   ii. **Frequency of services.** The State requires (select one):

   - (●) **The provision of waiver services at least monthly**
   - ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

   If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

   - ( ) **Directly by the Medicaid agency**
   - ( ) **By the operating agency specified in Appendix A**
   - ( ) **By an entity under contract with the Medicaid agency.**

   Specify the entity:

   - (●) **Other**
     Specify:

     Regional Centers

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

   Qualified Mental Retardation Professional (QMRP) as defined in 42 CFR §483.430(a).

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

   The level of care (LOC) criteria are based on California Code of Regulations (CCR) Title 22 §§ 51343, 51343.1 and 51343.2 which specify the LOC requirements for admittance to an intermediate care facility for the developmentally disabled (ICF/DD), ICF/DD-H (habilitative) or ICF/DD-N (nursing.) The Client Development Evaluation Report (CDER) is utilized in making LOC determinations.

   These regulations indicate that an individual must have at least two moderate or severe support needs (qualifying conditions) in one or a combination of the following areas: self-help (e.g. dressing, personal care, etc.); social-emotional (e.g. aggression, running away, etc.) ; or health (e.g. tracheostomy care, apnea monitoring, etc.)

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

   - (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
   - ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

When assessing level-of-care (LOC), the regional center QMRP reviews the CDER data including the diagnostic, special conditions and personal outcomes sections. In addition to the CDER data, the QMRP reviews other pertinent information in the consumer's record, such as the individual program plan, progress reports, medical and psychological evaluations and case management notes, to determine the Waiver qualifying conditions that significantly affect the consumer's ability to perform activities of daily living and/or participate in community activities. The qualifying conditions identified in this analysis are documented on the "Medicaid Waiver Eligibility Record" (DS 3770). The consumer must have a minimum of two qualifying conditions to meet the LOC requirements for this Waiver.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

Monthly State computer-generated reports of consumers who are due for reevaluation are provided to regional centers one month in advance of the annual reevaluation date. The processes in place to monitor this requirement are detailed in the Quality Improvement section below.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records are kept at each of the 21 regional centers in each participant's file.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new enrollees who had a LOC determination prior to waiver enrollment. Numerator = number of consumer records reviewed of new enrollees that documented an initial LOC determination prior to waiver enrollment. Denominator = total number of new enrollee consumer records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews	☐ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential

are conducted annually or more frequently as needed.		settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of HCBS Waiver consumers who had a level-of-care (LOC) reevaluation within 12 months of the initial determination or last annual redetermination. Numerator = number of consumers with timely LOC reevaluation. Denominator = total number of consumer records reviewed or number of all consumers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to

		the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Waiver Control Listing for Clients with Past Due Recertifications (Monthly computer generated report)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of level-of-care (LOC) determinations that were done utilizing the process outlined in the approved waiver. Numerator = number of consumer records reviewed that documented LOC determinations utilizing the process outlined in the approved waiver. Denominator = total number of consumer records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more	

	frequently as needed.

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of LOC determinations that were completed accurately. Numerator = number of consumer records reviewed that documented accurate LOC determinations. Denominator = total number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95%

		confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Individual level-of-care (LOC) issues (e.g. appropriateness, timeliness, etc.) identified during the State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews are documented in monitoring reports which are sent to the regional centers with the State's recommendations for resolution. The regional center's plans for correction submitted in response to the State's recommendations are evaluated and approved by DHCS and DDS before the final monitoring report is issued to the regional center and forwarded to CMS. Typically, the remediation for identified individual LOC issues involves 1) a reassessment of LOC to determine the areas of need, and 2) correction of documentation to ensure only qualifying conditions (issues requiring moderate or severe support needs) are used in making LOC determinations. When the results of these reassessments indicate the LOC criteria are not met, then the individual's waiver eligibility is terminated.

As referenced in Appendix B-6(i), timeliness of LOC reevaluations is also monitored on a statewide basis through automated monthly reports. DDS follow-up on each occurrence to ensure appropriate action is taken.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When an individual is determined to be likely to require a level of care described in Appendix B-6 of this request, the individual, or where appropriate his/her legal representative will be informed of any feasible alternatives under the DD waiver and given the choice of either institutional or services under the DD waiver.

The regional center will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home and community-based services as an alternative to institutional services, or who are denied the service(s), of their choice, or the providers of their choice. Individuals will be notified, in writing, of their fair hearing rights. The regional center case manager is responsible for informing individuals of the feasible alternatives for obtaining necessary services and giving each eligible individual the choice of receiving necessary care and services in an institutional health facility, through the DD waiver, or through the already approved HCBS Waiver for regional center consumers. The regional center case manager ensures that:

1. Individuals, their legal representative, parents, relatives, or involved persons are informed of the choice of either participating or not participating in the DD waiver, if the consumer is determined to be eligible for DD waiver services and chooses to receive DD waiver services in lieu of institutional services.
2. The individual's choice is documented on the Medicaid Waiver Consumer Choice of Services/Living Arrangement form (DS 2200) at the time of any of the following:
• Determination of initial eligibility for the DD waiver.
• Reactivation of the DD waiver eligibility after an individual's termination from participation in the DD waiver.
• Transition from minor to adult status.
3. The consumer's choice to participate in the waiver is documented in a dated and signed DS 2200.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The signed DS 2200 is retained in the participant's record at the regional center.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Under the provisions of the California Welfare and Institutions Code (WIC) §4641, regional centers are required to conduct outreach activities to inform their communities of their services and to actively pursue individuals in need of services. Outreach and other information developed and used by regional centers must be available in English and other languages that are reflective of the populations in the service area of the regional center. Outreach activities lead to persons with developmental disabilities finding or being referred to regional centers for intake and assessment and a determination of eligibility for services. DDS monitors and facilitates this requirement.

During intake and assessment, consumers are informed of feasible alternative services under the DD Waiver. To accomplish this, consumers and families must be able to communicate effectively with regional center staff and other members of the planning team. Every effort is made to communicate in the language of the consumer or family. These efforts include using a facilitator who may also be a member of the planning team, employing bilingual staff at the regional center, and/or using an interpreter or translator. In no case does a planning team proceed to develop a plan or explain alternatives that are not understood by the participant, or where appropriate a family member or legal representative. WIC §4502.1 requires that information be provided in an understandable form to aid the consumer in making choices by all public or private agencies receiving state funds for the purpose of providing services persons with developmental disabilities.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Behavioral Intervention Services**		
Statutory Service	**Community Living Arrangements**		
Statutory Service	**Day Service**		
Statutory Service	**Home Health Aide**		
Statutory Service	**Homemaker**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Respite Care**		
Statutory Service	**Supported Employment (Enhanced Habilitation)**		
Other Service	**Chore Services**		
Other Service	**Communication Aides**		
Other Service	**Community-Based Training Service**		
Other Service	**Dental Services**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Financial Management Service**		
Other Service	**Non-Medical Transportation**		
Other Service	**Nutritional Consultation**		
Other Service	**Optometric/Optician Services**		
Other Service	**Personal Emergency Response Systems (PERS)**		
Other Service	**Prescription Lenses and Frames**		
Other Service	**Psychology Services**		
Other Service	**Skilled Nursing**		
Other Service	**Specialized Medical Equipment and Supplies**		
Other Service	**Specialized Therapeutic Services**		
Other Service	**Speech, Hearing and Language Services**		
Other Service	**Transition/Set Up Expenses**		
Other Service	**Vehicle Modifications and Adaptations**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Behavioral Intervention Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Habilitation—Behavioral Intervention Services include two components:
A) Individual/Group Practitioners - which may provide Behavioral Intervention Services in multiple settings, including the individual's home, workplace, etc. depending on the individual's needs.
B) Crisis Support – If relocation becomes necessary, emergency housing in the person's home community is available. Crisis Support provides a safe, stable highly structured environment by combining concentrated, highly skilled staffing (e.g. psychiatric technicians, certified behavior analysts) and intensive behavior modification programs. Conditions that would qualify an individual for crisis support include aggression to others, self-injurious behavior, property destruction, or other pervasive behavior issues that have precluded effective treatment in the current living arrangement.
While the location and intensity of the components of this service vary based on the individual's needs, all components of behavioral intervention services include use and development of intensive behavioral intervention (see #1 below) programs to improve the recipient's development; and behavior tracking and analysis. The intervention programs will be restricted to generally accepted, evidence-based, positive approaches. Behavioral intervention services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Services may be provided to family members if they are for the benefit of the recipient. Services for family members may include training and instruction about treatment regimens and risk management strategies to enable the family to support the recipient.
The participation of parent(s) of minor children is critical to the success of a behavioral intervention plan. The person-centered planning team determines the extent of participation necessary to meet the individual's needs. "Participation" includes the following meanings: Completion of group instruction on the basics of behavior intervention; Implementation of intervention strategies, according to the intervention plan; If needed, collection of data on behavioral strategies and submission of that data to the provider for incorporation into progress reports; Participation in any needed clinical meetings; provision of suggested nominal behavior modification materials or community involvement if a reward system is used. If the absence of sufficient participation prevents successful implementation of the behavioral plan, other services will be provided to meet the individual's identified needs.
(1) "Intensive behavioral intervention" means any form of applied behavioral analysis (ABA) based treatment (see #2 below) that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.
(2) "Applied behavioral analysis based treatment" means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.
Behavioral Habilitation services do not include services otherwise available to the person under the Individuals with Disabilities Education Act or the Rehabilitation Act of 1973.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☑ **Relative**
☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Client/Parent Support Behavior Intervention Training
Agency	Behavior Management Consultant: Licensed Clinical Social Worker
Individual	Licensed Psychiatric Technician
Individual	Psychiatrist
Individual	Behavioral Technician / Paraprofessional
Individual	Crisis Team-Evaluation and Behavioral Intervention
Agency	Behavior Analyst
Individual	Behavior Management Assistant: (Psychology Assistant; Associate Licensed Clinical Social Worker)
Individual	Behavior Management Consultant: Marriage Family Child Counselor
Individual	Parenting Support Services Provider
Agency	Crisis Team-Evaluation and Behavioral Intervention
Agency	Behavior Management Assistant: (Psychology Assistant; Associate Licensed Clinical Social Worker)
Agency	Parenting Support Services Provider
Individual	Associate Behavior Analyst
Individual	Behavior Management Consultant: (Psychologist)
Agency	Associate Behavior Analyst
Agency	Psychiatrist
Agency	Individual or Family Training Provider
Individual	Behavior Analyst
Agency	Behavior Management Consultant: Marriage Family Child Counselor
Individual	Behavior Management Consultant: Licensed Clinical Social Worker
Agency	Behavioral Technician / Paraprofessional
Individual	Crisis Intervention Facility
Individual	Client/Parent Support Behavior Intervention Training
Individual	Family Counselor (MFCC), Clinical Social Worker (CSW)
Agency	Behavior Management Consultant: (Psychologist)
Individual	Individual or Family Training Provider
Agency	Crisis Intervention Facility
Agency	Licensed Psychiatric Technician

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Agency

Provider Type:
Client/Parent Support Behavior Intervention Training
Provider Qualifications
License *(specify):*
Licensed in accordance with Business and Professions Code as appropriate to the skilled professions of staff.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Refer to "Other Standard."
Other Standard *(specify):*
Client/Parent Support Behavior Intervention Training services may be provided by a Behavior Analyst, Behavior Analyst, Associate Behavior Analyst, Psychologist, Psychiatric Technician or Psychiatrist.
Specific qualifications and training of providers are as specified in the requirements established in this section.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Agency
Provider Type:
Behavior Management Consultant: Licensed Clinical Social Worker
Provider Qualifications
License *(specify):*
Business and Professions Code §§4996-4996.2

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual
Provider Type:
Licensed Psychiatric Technician
Provider Qualifications
License *(specify):*
Business and Professions Code §4500 et seq.

Possesses a valid psychiatric technician's license issued by the California State Board of Vocational Nurse and Psychiatric Technician Examiners

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual
Provider Type:
Psychiatrist
Provider Qualifications
License *(specify):*
Business and Professions Code, Division 2, Chapter 5, commencing at § 2000

Licensed as a physician and surgeon by the Medical Board of California.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Certified by the American Board of Psychiatry and Neurology
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Behavioral Technician / Paraprofessional

Provider Qualifications

License *(specify):*

No state licensing category

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Works under the direct supervision of a Behavior Analyst or Behavior Management Consultant.

(1) Has a High School Diploma or the equivalent, has completed 30 hours of competency-based training designed by a certified behavior analyst, and has six months experience working with persons with developmental disabilities;
or
(2) Possesses an Associate's Degree in either a human, social, or educational services discipline, or a degree or certification related to behavior management, from an accredited community college or educational institution, and has six months experience working with persons with developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:
Crisis Team-Evaluation and Behavioral Intervention
Provider Qualifications
License *(specify):*
Licensed in accordance with Business and Professions Code as appropriate to the skilled professions staff assigned to the team.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Certified as appropriate to the skilled professions staff assigned to the team.
Other Standard *(specify):*
Program utilizes licensed and/or certified personnel as appropriate to provide develop and implement individualized crisis behavioral services plans. Specific qualifications and training of personnel per agency guidelines consistent with requirements for Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant: Psychologist, Psychiatric Technician or Psychiatrist established in this section.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Agency
Provider Type:
Behavior Analyst
Provider Qualifications
License *(specify):*
Licensed in accordance with Business and Professions Code as appropriate to the skilled professions staff.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Certification by the national Behavior Analyst Certification Board.
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual

Provider Type:
Behavior Management Assistant: (Psychology Assistant; Associate Licensed Clinical Social Worker)

Provider Qualifications

License *(specify):*
As appropriate, a business license as required by the local jurisdiction where the business is located.

Business and Professions Code §2913; §4996-4996.2

Certificate *(specify):*
Registered as either:
1. A psychological assistant of a psychologist by the Medical Board of California or Psychology Examining Board; or
2. An Associate Licensed Clinical Social Worker pursuant to Business and Professions Code, Section 4996.18.

Other Standard *(specify):*
Possesses a Bachelor of Arts or Science Degree and has either:
1. Twelve semester units in applied behavior analysis and one year of experience in designing and/or implementing behavior modification intervention services; or
2. Two years of experience in designing and/or implementing behavior modification intervention services.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual

Provider Type:
Behavior Management Consultant: Marriage Family Child Counselor

Provider Qualifications

License *(specify):*
Business and Professions Code §§4980-4981

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Individual

Provider Type:

Parenting Support Services Provider

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Vendor must ensure that trainers are credentialed and/or licensed as required by the State of California to practice in the field of training being offered.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Crisis Team-Evaluation and Behavioral Intervention

Provider Qualifications

License *(specify):*

Licensed in accordance with Business and Professions Code as appropriate to the skilled professions staff assigned to the team.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified as appropriate to the skilled professions staff assigned to the team.

Other Standard *(specify):*

Program utilizes licensed and/or certified personnel as appropriate to provide develop and implement individualized crisis behavioral services plans. Specific qualifications and training of personnel per agency guidelines consistent with requirements for Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant: Psychologist, Psychiatric Technician or Psychiatrist established in this section.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Behavior Management Assistant: (Psychology Assistant; Associate Licensed Clinical Social Worker)

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Business and Professions Code §2913; §4996-4996.2

Certificate *(specify):*

Registered as either:
1. A psychological assistant of a psychologist by the Medical Board of California or Psychology Examining Board; or
2. An Associate Licensed Clinical Social Worker pursuant to Business and Professions Code, Section 4996.18.

Other Standard *(specify):*

Possesses a Bachelor of Arts or Science Degree and has either:
1. Twelve semester units in applied behavior analysis and one year of experience in designing and/or implementing behavior modification intervention services; or
2. Two years of experience in designing and/or implementing behavior modification intervention services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Agency
Provider Type:
Parenting Support Services Provider
Provider Qualifications
License *(specify):*
As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Vendor must ensure that trainers are credentialed and/or licensed as required by the State of California to practice in the field of training being offered.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual
Provider Type:
Associate Behavior Analyst
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Certification by the national Behavior Analyst Certification Board
Other Standard *(specify):*
Works under the direct supervision of a Behavior Analyst or Behavior Management Consultant.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as

applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual

Provider Type:
Behavior Management Consultant: (Psychologist)

Provider Qualifications

License *(specify):*
Business and Professions Code, §2940-2948

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Agency

Provider Type:
Associate Behavior Analyst

Provider Qualifications

License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
Certification by the national Behavior Analyst Certification Board

Other Standard *(specify):*

Works under the direct supervision of a Behavior Analyst or Behavior Management Consultant.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Psychiatrist

Provider Qualifications

License *(specify):*

Business and Professions Code, Division 2, Chapter 5, commencing at § 2000

Licensed as a physician and surgeon by the Medical Board of California.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified by the American Board of Psychiatry and Neurology

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:

Individual or Family Training Provider

Provider Qualifications

License *(specify):*
As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Vendor must ensure that trainers are credentialed and/or licensed as required by the State of California to practice in the field of training being offered.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual
Provider Type:
Behavior Analyst
Provider Qualifications

License *(specify):*
Licensed in accordance with Business and Professions Code as appropriate to the skilled professions staff.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Certification by the national Behavior Analyst Certification Board.
Other Standard *(specify):*
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:

Agency

Provider Type:
Behavior Management Consultant: Marriage Family Child Counselor
Provider Qualifications
License *(specify):*
Business and Professions Code §§4980-4981

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual

Provider Type:
Behavior Management Consultant: Licensed Clinical Social Worker
Provider Qualifications
License *(specify):*
Business and Professions Code §§4996-4996.2

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Agency
Provider Type:
Behavioral Technician / Paraprofessional
Provider Qualifications
License *(specify):*
No state licensing category

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Works under the direct supervision of a Behavior Analyst or Behavior Management Consultant.

(1) Has a High School Diploma or the equivalent, has completed 30 hours of competency-based training designed by a certified behavior analyst, and has
six months experience working with persons with developmental disabilities;
or
(2) Possesses an Associate's Degree in either a human, social, or educational services discipline, or a degree or certification related to behavior management, from an accredited community college or educational institution, and has six months experience working with persons with developmental disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual
Provider Type:
Crisis Intervention Facility
Provider Qualifications
License *(specify):*
Health and Safety Code §§1500-1569.889

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Refer to "Other Standard."
Other Standard *(specify):*
Crisis services may be provided in any of the types of 24-hour care services identified in Habilitation – Community Living Arrangement Services (CLAS) section. Refer to the CLAS section for standards.
Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual
Provider Type:
Client/Parent Support Behavior Intervention Training
Provider Qualifications
License *(specify):*
Licensed in accordance with Business and Professions Code as appropriate to the skilled professions of staff.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Refer to "Other Standard."
Other Standard *(specify):*
Client/Parent Support Behavior Intervention Training services may be provided by a Behavior Analyst, Behavior Analyst, Associate Behavior Analyst, Psychologist, Psychiatric Technician or Psychiatrist.
Specific qualifications and training of providers are as specified in the requirements established in this section.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual
Provider Type:
Family Counselor (MFCC), Clinical Social Worker (CSW)
Provider Qualifications
License *(specify):*
Valid license with the California Board of Behavioral Science Examiners

As appropriate, a business license as required by the local jurisdiction where the business is located.

MFCC: Business and Professions Code §§4980-4984.9

CSW: Business and Professions Code §§4996-4997
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Agency
Provider Type:
Behavior Management Consultant: (Psychologist)
Provider Qualifications
License *(specify):*
Business and Professions Code, §2940-2948

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Vendored by the regional center in accordance with Title 17, CCR, § 54342(a)(13)
Verification of Provider Qualifications
Entity Responsible for Verification:
Vendored by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Individual

Provider Type:
Individual or Family Training Provider

Provider Qualifications

License *(specify):*
As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
Vendor must ensure that trainers are credentialed and/or licensed as required by the State of California to practice in the field of training being offered.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Agency

Provider Type:
Crisis Intervention Facility

Provider Qualifications

License *(specify):*
Health and Safety Code §§1500-1569.889

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
Refer to "Other Standard."

Other Standard *(specify):*
Crisis services may be provided in any of the types of 24-hour care services identified in Habilitation – Community Living Arrangement Services (CLAS) section. Refer to the CLAS section for standards.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service

design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Behavioral Intervention Services

Provider Category:
Agency

Provider Type:
Licensed Psychiatric Technician

Provider Qualifications

License *(specify):*
Business and Professions Code §4500 et seq.

Possesses a valid psychiatric technician's license issued by the California State Board of Vocational Nurse and Psychiatric Technician Examiners

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):
Community Living Arrangements

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Habilitation—Community Living Arrangement Services (CLAS) includes two components, based on the setting:
A) Licensed/certified settings - CLAS provided in these settings include assistance with acquisition, retention, or improvement in skills related to living in the community. Services and supports include assistance with activities of daily living, (e.g. personal grooming and cleanliness, bed making and household chores, eating and the preparation of food), community inclusion, social and leisure skill development and the adaptive skills necessary to enable the individual to reside in a non-institutional setting.

Services provided in licensed/certified settings will take into consideration the provision of the following:
1. Private or semi-private bedrooms shared by no more than two persons with personal décor. The choice of residential settings, including making decisions regarding sharing a bedroom, is made during the person-centered planning process.
2. Private or semi-private bathrooms. The residence must have enough bathroom space to ensure residents' privacy for personal hygiene, dressing, etc.
3. Common living areas or shared common space for interaction between residents, and residents and their guests.
4. Residents must have access to a kitchen area at all times.
5. Residents' opportunity to make decisions on their day-to-day activities, including visitors and when and what to eat, in their home and in the community.
6. Services which meet the needs of each resident.
7. Assurance of residents rights: a) to be treated with respect; b) choose and wear their own clothes; c) have private space to store personal items; d) have private space to visit with friends and family; e) use the telephone with privacy; f) choose how and with whom to spend free time; and h) have opportunities to take part in community activities of their choice.

Settings that contain multiple independent living units (e.g. apartments) are considered home-like settings for the purposes of this Waiver.

B) Supported living services (provided in residences owned or leased by the recipients.) - CLAS provided in these settings are tailored supports that provide assistance with acquisition, retention, or improvement in skills related to:
• Activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of meals, including planning, shopping, cooking, and storage activities;
• Social and adaptive skills necessary for participating in community life, such as building and maintaining interpersonal relationships, including a Circle of Support;
• Locating and scheduling appropriate medical services;
• Managing personal financial affairs;
• Selecting and moving into a home;
• Locating and choosing suitable house mates;
• Acquiring household furnishings;
• Recruiting, training, and hiring personal attendants;
• Acquiring, using, and caring for canine and other animal companions specifically trained to provide assistance;
• Acquiring, using and maintaining devices to facilitate immediate assistance when threats to health, safety, and well-being occur.

CLAS may include additional activities, as appropriate, to meet the recipients' unique needs. These activities include those that address social, adaptive, behavioral, and health care needs as identified in the individual program plan. CLAS may also include the provision of medical and health care services that are integral to

meeting the daily needs of residents (e.g., routine administration of medications or tending to the needs of residents who are ill or require attention to their medical needs on an ongoing basis). Medical and health care services such as physician services that are not routinely provided to meet the daily needs of residents are not included.

The specific services provided to each recipient vary based on the residential setting chosen and needs identified in the individual program plan.

Payments will not be made for the routine care and supervision which would be expected to be provided by a family, or for activities or supervision for which a payment is made by a source other than Medi-Cal. Payments for CLAS in licensed/certified settings do not include the cost for room and board. The method by which the costs of room and board are excluded from payment in these settings is specified in Appendix I-5.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Family Home Agency(FHA): Adult Family Home(AFH)/Family Teaching Home(FTH)
Agency	Residential Care Facility for the Elderly (RCFE)
Agency	Small Family Homes (Children Only)
Agency	Foster Family Agency (FFA)-Certified Family Homes (Children Only)
Agency	Residential Facility (out of state)
Agency	Supported Living Provider
Agency	Adult Residential Facility for Persons with Special Health Care Needs
Agency	Foster Family Homes (FFHs) (Children Only)
Agency	Group Homes (Children Only)
Agency	Adult Residential Facilities (ARF)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangements

Provider Category:
Agency
Provider Type:
Family Home Agency(FHA): Adult Family Home(AFH)/Family Teaching Home(FTH)
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
AFH Title 17, CCR, §56088
Authorizes the FHA to issue a Certificate of Approval to each family home which has:
1. Completed the criminal record review ;
2. Been visited by the FHA and a determination ensuring safe and reasonable and the prospective providers experience, knowledge, cooperation, history and interest to
become an approved family home.
3. Completed required orientation and training.
Other Standard *(specify):*
Welfare and Institutions Code 4689.1-4689.6 provides statutory authority for FHA.

FHA employs sufficient staff with the combined experience, training and education to perform the following duties:
1. Administration of the FHA;
2. Recruitment of family homes;
3. Training of FHA staff and family homes;
4. Ensuring an appropriate match between the needs and preferences of the consumer and the family home;
5. Monitoring of family homes;
6. Provision of services and supports to consumers and family homes which are consistent with the consumer's preferences and needs and the consumer's IPP; and
7. Coordination with the regional center and others.

In order to accomplish these duties, selection criteria for hiring purposes should include but not be limited to: education in the fields of social work, psychology, education of related areas; experience with persons with developmental disabilities; experience in program management, fiscal management and organizational development.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Regional Centers
DDS

Family Home Agency

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually
Biennially

Monthly

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangements

Provider Category:
Agency

Provider Type:
Residential Care Facility for the Elderly (RCFE)

Provider Qualifications

License *(specify):*
Health and Safety Code §§1569-1569.889 provides statutory authority for licensing of RCFEs. Identified as the CA Residential Care Facilities for the Elderly Act.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
Title 22, CCR, §§87100-87793: Establish licensing requirements for facilities where 75 percent of the residents are sixty years of age or older. Younger residents must have needs compatible with other residents.

Administrator Qualifications:
1. Knowledge of the requirements for providing care and supervision appropriate to the residents.
2. Knowledge of and ability to conform to the applicable laws, rules and regulations.
3. Ability to maintain or supervise the maintenance of financial and other records.
4. Ability to direct the work of others.
5. Good character and a continuing reputation of personal integrity.
6. High school diploma or equivalent.
7. At least 21 years of age.
8. Criminal Record Clearance.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangements

Provider Category:
Agency

Provider Type:
Small Family Homes (Children Only)

Provider Qualifications

License *(specify):*
Health and Safety Code §§1500-1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
Title 22, CCR §§ 83000-83088.
Regulations adopted by DSS to specify requirements for licensure of Small Family Homes.

Licensee/Administrator Qualifications
- Criminal Records/Child Abuse Index Clearance;
- At least 18 years of age;
- Documented education, training, or experience in providing family home care and supervision appropriate to the type of children to be served. The amount of units or supervision appropriate to the type of children to be served. The amount of units or training hours is not specified. The following are examples of acceptable education or training topics. Programs which can be shown to be similar are accepted:
o Child Development;
o Recognizing and/or dealing with learning disabilities;
o Infant care and stimulation;
o Parenting skills;
o Complexities, demands and special needs of children in placement;
o Building self esteem, for the licensee or the children;
o First aid and/or CPR;
o Bonding and/or safeguarding of children's property;
o Ability to keep financial and other records;
o Ability to recruit, employ, train, direct the work of and evaluate qualified staff.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangements

Provider Category:
Agency

Provider Type:
Foster Family Agency (FFA)-Certified Family Homes (Children Only)

Provider Qualifications

License *(specify):*
FFA licensed pursuant to Health and Safety Code §§1500-1567.8 provides statutory authority for DSS licensing of facilities identified in the CA Community Care Facilities Act.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
Certified Family Homes; Title 22, CCR, § 88030 establishes requirements for FFA certification of family homes

Other Standard *(specify):*
Title 22, CCR §§ 88000-88087. Regulations adopted by DSS to specify requirements for licensure of FFA's, certification and use of homes,

FFA administrator qualifications:

(1) A Master's Degree in social work or a related field. Three years of experience in the field of child or family services, two years of which have been administrative/ managerial; or,

(2) A Bachelor's Degree in a behavioral science from an accredited college or university. A minimum of five years of experience in child or family services, two years of which have been in an administrative or managerial position.

Certified family home providers meet requirements for foster family homes (Refer to Foster Family Homes below).

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangements

Provider Category:

Agency

Provider Type:

Residential Facility (out of state)

Provider Qualifications

License *(specify):*

Appropriate Facility License, as required by State law.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Department approval is required per the Welfare and Institutions Code, § 4519.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangements

Provider Category:
Agency
Provider Type:
Supported Living Provider
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
SLS requirements:
1. Service design including:
- Staff hiring criteria, including any minimum qualifications requirements; and
- Procedures and practices the agency will use to screen paid staff, consultants, and volunteers who will have direct contact with consumers.
2. Staff appropriate to services rendered with skills to establish and maintain constructive and appropriate personal relationship with recipients, minimize risks of endangerment to health, safety, and well-being of recipients, perform CPR and operate 24-hour emergency response systems, achieve the intended results of services being performed and maintenance of current and valid licensure, certification, or registration as are legally required for the service.
3. Staff orientation and training in theory and practice of supported living services and recipient training in supported living services philosophy, recipient rights, abuse prevention and reporting, grievance procedures and strategies for building and maintaining a circle of support.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangements

Provider Category:
Agency
Provider Type:
Adult Residential Facility for Persons with Special Health Care Needs
Provider Qualifications
License *(specify):*
Health and Safety Code §§1500-1569.87

Appropriate license DSS CCLD as to type of facility

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Welfare and Institutions Code, § 4684.50 et seq.

The administrator must:
1. Complete the 35-houradministrator certification program pursuant to paragraph (1) of subdivision (c) of Section 1562.3 of the Health and Safety Code without exception,
2. Has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities, and is one or more of the following:
a. A licensed registered nurse.
b. A licensed nursing home administrator.
c. A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities.
d. An individual with a bachelors degree or more advanced degree in the health or human services field and two years experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangements

Provider Category:
Agency

Provider Type:
Foster Family Homes (FFHs) (Children Only)

Provider Qualifications

License *(specify):*
Health and Safety Code §§1500-1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
Title 22, CCR §§89200-89587.1
Regulations adopted by DSS to specify requirements for licensure of Foster Family Homes.

Qualifications/Requirements for FFH providers:
1. Comply with applicable laws and regulations and:
2. Provide care and supervision to meet the child's needs including communicating with the child;
3. Maintain all child records, safeguard cash resources and personal property;
4. Direct the work of others in providing care when applicable,
5. Apply the reasonable and prudent parent standard;
6. Promote a normal, healthy, balanced, and supported childhood experience and treat a child as part of the family;
7. Attend training and professional development;

8. Criminal Records/Child Abuse Registry clearance;
9. Report special incidents;
10. Ensure each child's personal rights; and,
11. Maintain a clean, safe, health home environment.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangements

Provider Category:

Agency

Provider Type:

Group Homes (Children Only)

Provider Qualifications

License *(specify):*

Health and Safety Code
§§ 1500-1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Title 22, CCR, § 84000-84808
Regulations adopted by DSS to specify requirements for licensure of Group Homes.
Administrator Qualifications:
1. Master's degree in a behavioral science, plus a minimum of one year of employment as a social worker in an agency serving children or in a group residential program for children;
2. Bachelor's degree, plus at least one year of administrative or supervisory experience (as above);
3. At least two years of college, plus at least two years administrative or supervisory experience (as above); or
4.Completed high school, or equivalent, plus at least three years administrative or supervisory experience (as above); and,
5. Criminal Records/Child Abuse Registry Clearance

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community Living Arrangements

Provider Category:
Agency
Provider Type:
Adult Residential Facilities (ARF)
Provider Qualifications

License *(specify):*
Health and Safety Code
§§ 1500 through 1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Title 22, CCR, §§85000-85092: Establish licensing requirements for persons 18 years of age through 59 years of age; and persons 60 years of age and older by exception.

Administrator Qualifications
- At least 21 years of age;
- High school graduation or a GED;
- Complete a program approved by DSS that consists of 35 hours of classroom instruction
o 8 hrs. in laws, including resident's personal rights, regulations, policies, and procedural standards that impact the operations of adult residential facilities;
o 3 hrs. in business operations;
o 3 hrs. in management and supervision of staff;
o 5 hrs. in the psychosocial needs of the facility residents;
o 3 hrs. in the use of community and support services to meet the resident's needs;
o 4 hrs. in the physical needs of the facility residents;
o 5 hrs. in the use, misuse and interaction of drugs commonly used by facility residents;
o 4 hrs. on admission, retention, and assessment procedures;
- Pass a standardized test, administered by the Department of Social Services with a minimum score of 70%.
- Criminal Record/Child Abuse Registry Clearance.

Additional Administrator Qualifications may also include:
- Has at least one year of administrative and supervisory experience in a licensed residential program for persons
- with developmental disabilities, and
is one or more of the following:
(A) A licensed registered nurse.
(B) A licensed nursing home administrator.
(C) A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities.
(D) An individual with a bachelors degree or more advanced degree in the health or human services field and two years experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Day Habilitation
Alternate Service Title (if any):
Day Service

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Habilitation – Day Services includes three components:
A) Community-Based Day Services – (Providers identified with "CB" below)
These services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which may take place in a residential or non-residential setting. Services may be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care. These services enable the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation service may serve to reinforce skills or lessons taught in school, therapy, or other settings. Day habilitation services may include paid/volunteer work strategies when the individualized planning process determines that supported employment or prevocational services are not appropriate for the individual. B) Activity-Based/Therapeutic Day Services – (Providers identified with "AT" below)
These services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills through therapeutic and/or physical activities and are designed to:
• Gain insight into problematic behavior
• Provide opportunities for expression of needs and feelings
• Enhance gross and fine motor development
• Promote language development and communication skills
• Increase socialization and community awareness

• Improve communication skills
• Provide visual, auditory and tactile awareness and perception experiences
• Assist in developing appropriate peer interactions
C) Mobility Related Day Services - (Providers identified with "MT" below)
These services foster the acquisition of greater independence and personal choice by teaching individuals how to use public transportation or other modes of transportation which will enable them to move about the community independently.

The above described services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 (29 USC Section 730) or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 USC 1401(16 and 17).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A consumer may receive specialized recreation and non-medical therapies (including, but not limited to, art, dance, and music) when the regional center determines that the service is a primary or critical means for ameliorating the physical, cognitive, or psychosocial effects of the consumer's developmental disability, or the service is necessary to enable the consumer to remain in his or her home and no alternative service is available to meet the consumer's need.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Mobility Training Services Agency (MT)
Individual	Independent Living Specialist (CB)
Agency	Independent Living Program (CB)
Agency	Social Recreation Program (CB)
Individual	Mobility Training Services Specialist (MT)
Agency	Behavior Management Program (CB)
Individual	Music Therapist (AT)
Individual	Adaptive Skills Trainer (CB)
Individual	Specialized Recreational Therapist
Agency	Creative Art Program (AT)
Individual	Socialization Training Program; Community Integration Training Program: Community Activities Support Service (CB)
Agency	Activity Center (CB)
Agency	Socialization Training Program; Community Integration Training Program: Community Activities Support Service (CB)
Individual	Recreational Therapist (AT)
Individual	Personal Assistant (CB)
Agency	Specialized Recreational Therapist (AT)
Individual	Special Olympics Trainer (AT)
Agency	Adult Development Centers (CB)
Agency	In-Home Day Program (CB)
Individual	Dance Therapist (AT)
Individual	Art Therapist (AT)

Provider Category	Provider Type Title
Agency	Sports Club: (e.g. YMCA, Community Parks and Recreation Program, Community-based recreation program) (AT)
Individual	Driver Trainer (MT)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Agency
Provider Type:
Mobility Training Services Agency (MT)
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Personnel providing this service possess the skill, training or education necessary to teach individuals how to use public transportation or other modes of transportation which enable them to move about the community independently including:
a) previous experience working with individuals with developmental disabilities and awareness of associated problems, attitudes and behavior patterns;
b) a valid California Driver's license and current insurance;
c) ability to work independently with minimal supervision according to specific guidelines; and
d) flexibility and adaptive skills to facilitate individual recipient needs.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Individual
Provider Type:
Independent Living Specialist (CB)
Provider Qualifications
License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Possesses the skill, training, or education necessary to teach recipients to live independently and/or to provide the supports necessary for the recipient to maintain a self-sustaining, independent living situation in the community, such as one year experience providing services to individuals in a residential or non-residential setting and possession of at least a two-year degree in a subject area related to skills training and development of program plans for eligible individuals.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Agency
Provider Type:
Independent Living Program (CB)

Provider Qualifications

License *(specify):*
Facility license (Health and Safety Code §§ 1500-1567.8) if applicable

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Requires written program design, recipient entrance and exit criteria, staff training, etc.

Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Agency
Provider Type:
Social Recreation Program (CB)
Provider Qualifications
License *(specify):*
Facility license (Health and Safety Code §§ 1500-1567.8) if applicable

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Requires written program design, recipient entrance and exit criteria, staff training, etc.

Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Individual
Provider Type:
Mobility Training Services Specialist (MT)
Provider Qualifications
License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Individuals providing this service possess the following minimum requirements:
1. Previous experience working with individuals with developmental disabilities and awareness of associated problems, attitudes and behavior patterns;
2. A valid California Driver's license and current insurance;
3. Ability to work independently, flexibility and adaptive skills to facilitate individual recipient needs.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Agency
Provider Type:
Behavior Management Program (CB)
Provider Qualifications

License *(specify):*
Facility license (Health and Safety Code §§ 1500-1567.8) if applicable.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Requires written program design, recipient entrance and exit criteria, staff training, etc.

Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.
Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Individual
Provider Type:
Music Therapist (AT)
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Valid registration issued by the National Association for Music Therapy.
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Individual
Provider Type:
Adaptive Skills Trainer (CB)
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Individual providing this service shall possess:
1. Master's degree in education, psychology, counseling, nursing, social work, applied behavior

analysis, behavioral medicine, speech and language or rehabilitation; and
2. At least one year of experience in the designing and implementation of adaptive skills training plans.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Individual

Provider Type:
Specialized Recreational Therapist

Provider Qualifications

License *(specify):*
Credentialed and/or licensed as required by the State in the field of therapy being offered.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
Equestrian therapists shall possess a current accreditation and instructor certification with the North American Riding for the Handicapped Association

Other Standard *(specify):*
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Agency

Provider Type:
Creative Art Program (AT)

Provider Qualifications

License *(specify):*
Facility license (Health and Safety Code §§ 1500-1567.8) if applicable

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
Program Director: Equivalent of a high school diploma and experience with persons with developmental disabilities.

Direct Care Staff: Must have artistic experience as demonstrated through a resume.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Individual

Provider Type:
Socialization Training Program; Community Integration Training Program: Community Activities Support Service (CB)

Provider Qualifications

License *(specify):*
Facility license (Health and Safety Code §§ 1500-1567.8) if applicable

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
Qualifications and training of staff per agency guidelines.

For Community Integration Training Program: Program directors must have at least a bachelor's degree. Direct service workers may be qualified by experience.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Agency
Provider Type:
Activity Center (CB)
Provider Qualifications

License *(specify):*
Facility license (Health and Safety Code §§ 1500-1567.8) if applicable

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
Requires written program design, recipient entrance and exit criteria, staff training, etc.

Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:
Socialization Training Program; Community Integration Training Program: Community Activities Support Service (CB)

Provider Qualifications

License *(specify):*
Facility license (Health and Safety Code §§ 1500-1567.8) if applicable

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
Qualifications and training of staff per agency guidelines.

For Community Integration Training Program: Program directors must have at least a bachelor's degree. Direct service workers may be qualified by experience.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:
Recreational Therapist (AT)

Provider Qualifications

License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
Certification issued by either the National Council for Therapeutic Recreation Certification or the California Board of Recreation and Park Certification.

Other Standard *(specify):*
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for

the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Individual

Provider Type:
Personal Assistant (CB)

Provider Qualifications

License *(specify):*
No state licensing category

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
Ability to provide assistance and support to meet Habilitation-Day Services needs as outlined in an individual program plan.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Agency

Provider Type:
Specialized Recreational Therapist (AT)

Provider Qualifications

License *(specify):*
Credentialed and/or licensed as required by the State in the field of therapy being offered

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:

Special Olympics Trainer (AT)

Provider Qualifications

License *(specify):*

No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Knowledge and training sufficient to ensure consumer participation in Special Olympics.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Adult Development Centers (CB)

Provider Qualifications

License *(specify):*

Facility license (Health and Safety Code §§ 1500-1567.8) if applicable)

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Requires written program design, recipient entrance and exit criteria, staff training, etc.

Director must have BA/BS with 18 months experience in human services delivery, or five years experience in human services delivery field. Supervisory staff must have three years experience plus demonstrated supervisory skills.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Agency
Provider Type:
In-Home Day Program (CB)
Provider Qualifications

License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Qualifications and training for staff in agency guidelines.

Must have a provision for an annual assessment process to ensure consumer participation in this type of program remains appropriate.

Providers may include employees of community-based day, pre-vocation, or vocational programs.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Individual
Provider Type:
Dance Therapist (AT)
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Validly registered as a dance therapist by the American Dance Therapy Association
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:
Individual
Provider Type:
Art Therapist (AT)
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Current registration issued by the American Art Therapy Association.
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Agency

Provider Type:

Sports Club: (e.g. YMCA, Community Parks and Recreation Program, Community-based recreation program) (AT)

Provider Qualifications

License *(specify):*

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

All community recreational program providers shall possess the following minimum qualifications:

1. Ability to perform the functions required by the individual plan of care;
2. Demonstrated dependability and personal integrity;
3. Willingness to pursue training as necessary based upon the individual consumer's needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Service

Provider Category:

Individual

Provider Type:

Driver Trainer (MT)

Provider Qualifications

License *(specify):*

Valid California driver's license

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Current certification by the California Department of Motor Vehicles as a driver instructor.
Other Standard *(specify):*
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Home Health Aide
Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services defined in 42 CFR §440.70 that are provided when home health aide services furnished under the approved State plan limits are exhausted. Home health aide services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.
The scope and nature of these services do not differ from home health aide services furnished under the State plan. Services are defined in the same manner as provided in the approved State plan. The provider qualifications specified in the State plan apply.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Home Health Aide
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Health Aide

Provider Category:
Individual
Provider Type:
Home Health Aide
Provider Qualifications
License *(specify):*
Health and Safety Code §§1725-1742

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Title 22, CCR § 74746

Complete a training program approved by the California Department of Public Health and is certified pursuant to Health and Safety Code § 1736.1.
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
California Department of Public Health

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
No less than every three years

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Health Aide

Provider Category:

Agency

Provider Type:
Home Health Agencies
Provider Qualifications
License *(specify):*
Health and Safety Code §§1725-1742

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Medi-Cal certification using Medicare standards, Title 22, CCR, §51217.
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
California Department of Public Health

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
No less than every three years

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Homemaker
Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
None

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Service Agency
Individual	Paid individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Service Agency
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Must employ, train and assign personnel who maintain, strengthen, or safeguard the care of individuals in their homes.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:
Paid individual
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Individual providers of homemaker services shall have the ability to maintain, strengthen, or safeguard the care of individuals in their homes.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Prevocational Services
Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
 Work activity programs are defined in California Welfare and Institutions Code §4851(e). These services are usually provided in a segregated setting and provide a sufficient amount and variety of work to prepare and maintain eligible adult individuals at their highest level of vocational functioning. Individuals receive compensation based upon their performance and upon prevailing wage. Accordingly, the rate of compensation for any individual varies, and may exceed 50% of minimum wage, because of variations in the prevailing wage rate for particular tasks and the individual's performance. Services are limited to:
o Work services consisting of remunerative employment which occur no less than 50% of the individual's time in program, as defined in Title 17, California Code of Regulations, Section 58820(c)(1).
o No more than 50% of the individual's time in program can be spent in a combination of work adjustment and

supportive habilitation services.
o Work adjustment services, as defined in Title 17, California Code of Regulations, Section 58820(c)(2)(A)(1-9), consisting of:
 Physical capacities development
 Psychomotor skills development
 Interpersonal and communicative skills
 Work habits development
 Development of vocationally appropriate dress and grooming
 Productive skills development
 Work practices training
 Work-related skills development
 Orientation and preparation for referral to Vocational Rehabilitation.

o Supportive habilitation services as defined in Title 17, California Code of Regulations, §58820(c)(2)(B)(1-5):
 Personal safety practices training
 Housekeeping maintenance skills development
 Health and hygiene maintenance skills development
 Self-advocacy training, individual counseling, peer vocational counseling, career counseling and peer club participation
 Other regional center approved vocationally related activities

o The above-described services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 (29 USC Section 730) or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Work Activity Program

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:
Work Activity Program
Provider Qualifications
License *(specify):*
Facility license (Health and Safety Code §§ 1500-1567.8) if applicable

Federal/State Tax Exempt Letter.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Programs must initially meet the Department of Rehabilitation Program certification standards and be accredited by CARF within four years of providing services.
Other Standard *(specify):*
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Commission on Accreditation of Rehabilitation Facilities (CARF
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Within four years at start-up; every one to three years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Respite
Alternate Service Title (if any):
Respite Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Intermittent or regularly scheduled temporary non-medical care (with the exception of colostomy, ileostomy, catheter maintenance, and gastrostomy) and supervision provided in the recipient's own home or in an approved out of home location to do all of the following:
1. Assist family members in maintaining the recipient at home;
2. Provide appropriate care and supervision to protect the recipient's safety in the temporary absence of family members;
3. Temporarily relieve family members from the constantly demanding responsibility of caring for a recipient; and
4. Attend to the recipient's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of usual daily routines which would ordinarily be performed by family members.

Respite may only be provided when the care and supervision needs of a consumer exceed that of a person of the

same age without developmental disabilities.

Respite also includes the following subcomponent:

Family Support Respite – Regularly provided care and supervision of children, for periods of less than 24 hours per day, while the parents/primary non-paid caregiver are out of the home.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care may be provided in the following locations:

- Private residence
- Residential licensed by the Department of Social Services.
- Respite facility licensed by the Department of Social Services
- Other community setting approved by the State that is not a private residence, such as:

oAdult Family Home/Family Teaching Home
oCertified Family Homes for Children
oAdult Day Care Facility
oCamp
oChild Day Care Facility
oLicensed Preschool

A regional center may offer vouchers to family members or adult consumers to allow the families and consumers to procure their own respite services.

Respite services do not duplicate services provided under the Individuals with Disabilities Education Act (IDEA) of 2004.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A consumer may receive up to 21 days of out-of-home respite services in a fiscal year, and up to 90 hours of in-home respite in a quarter unless it is demonstrated that the intensity of the consumer's care and supervision needs are such that additional respite is necessary to maintain the consumer in the family home, or there is an extraordinary event that impacts the family member's ability to meet the care and supervision needs of the consumer. Service limitations do not apply to family support respite.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)
Agency	Camping Services
Agency	Respite Facility; Residential Facility: Residential Care Facility for the Elderly (RCFE)
Agency	Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
Agency	Respite Facility; Residential Facility: Small Family Homes (Children Only)
Agency	Child Day Care Facility; Child Day Care Center; Family Child Care Home
Agency	Adult Day Care Facility

Provider Category	Provider Type Title
Agency	Respite Facility; Residential Facility: Family Home Agency(FHA): Adult Family Home (AFH)/Family Teaching Home(FTH)
Individual	Individual
Agency	Respite Facility; Residential Facility: Group Homes (Children Only)
Agency	Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
Agency	Respite Agency
Agency	Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)
Provider Qualifications
License *(specify):*
Health and Safety Code §§1500-1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Title 22, CCR §§89200-89587.1
Regulations adopted by DSS to specify requirements for licensure of Foster Family Homes.

Qualifications/Requirements for FFH providers:
1. Comply with applicable laws and regulations and:
2. Provide care and supervision to meet the child's needs including communicating with the child;
3. Maintain all child records, safeguard cash resources and personal property;
4. Direct the work of others in providing care when applicable,
5. Apply the reasonable and prudent parent standard;
6. Promote a normal, healthy, balanced, and supported childhood experience and treat a child as part of the family;
7. Attend training and professional development;
8. Criminal Records/Child Abuse Registry clearance;
9. Report special incidents;
10. Ensure each child's personal rights; and,
11. Maintain a clean, safe, health home environment.

Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
Camping Services
Provider Qualifications
License *(specify):*
As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
The camp submits to the local health officer either
1) Verification that the camp is accredited by the American Camp Association or
2) A description of operating procedures that addresses areas including supervisor qualifications and staff skill verification criteria.
Other Standard *(specify):*
Camp Director Qualifications: must be at least 25 years of age, and have at least two seasons of administrative or supervisory experience in camp activities.

Health Supervisor (physician, registered nurse or licensed vocational nurse) employed full time will verify that all counselors have been trained in first aid and CPR.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
Respite Facility; Residential Facility: Residential Care Facility for the Elderly (RCFE)
Provider Qualifications
License *(specify):*
Health and Safety Code §§1569-1569.889 provides statutory authority for licensing of RCFEs. Identified as the CA Residential Care Facilities for the Elderly Act.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

N/A

Other Standard *(specify):*

Title 22, CCR, §§87100-87793: Establish licensing requirements for facilities where 75 percent of the residents are sixty years of age or older. Younger residents must have needs compatible with other residents.

Administrator Qualifications:
1. Knowledge of the requirements for providing care and supervision appropriate to the residents.
2. Knowledge of and ability to conform to the applicable laws, rules and regulations.
3. Ability to maintain or supervise the maintenance of financial and other records.
4. Ability to direct the work of others.
5. Good character and a continuing reputation of personal integrity.
6. High school diploma or equivalent.
7. At least 21 years of age.
8. Criminal Record Clearance.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)

Provider Qualifications

License *(specify):*

FFA licensed pursuant to Health and Safety Code §§1500-1567.8 provides statutory authority for DSS licensing of facilities identified in the CA Community Care Facilities Act.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Certified Family Homes; Title 22, CCR, § 88030 establishes requirements for FFA certification of family homes.

Other Standard *(specify):*

Title 22, CCR §§ 88000-88087. Regulations adopted by DSS to specify requirements for licensure of FFA's, certification and use of homes,

FFA administrator qualifications:
(1) A Master's Degree in social work or a related field. Three years of experience in the field of child or family services, two years of which have been administrative/ managerial; or,

(2) A Bachelor's Degree in a behavioral science from an accredited college or university. A minimum of five years of experience in child or family services, two years of which have been in an administrative or managerial position.

Certified family home providers meet requirements for foster family homes (Refer to Foster Family Homes below).

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Respite Facility; Residential Facility: Small Family Homes (Children Only)

Provider Qualifications

License *(specify):*

Health and Safety Code §§1500-1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

N/A

Other Standard *(specify):*

Title 22, CCR §§ 83000-83088.
Regulations adopted by DSS to specify requirements for licensure of Small Family Homes.
Licensee/Administrator Qualifications
- Criminal Records/Child Abuse Index Clearance;
- At least 18 years of age;
- Documented education, training, or experience in providing family home care and supervision appropriate to the type of children to be served. The amount of units or supervision appropriate to the type of children to be served. The amount of units or training hours is not specified. The following are examples of acceptable education or training topics. Programs which can be shown to be similar are accepted:
o Child Development;
o Recognizing and/or dealing with learning disabilities;
o Infant care and stimulation;
o Parenting skills;
o Complexities, demands and special needs of children in placement;
o Building self esteem, for the licensee or the children;
o First aid and/or CPR;

o Bonding and/or safeguarding of children's property;
o Ability to keep financial and other records;
o Ability to recruit, employ, train, direct the work of and evaluate qualified staff.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Child Day Care Facility; Child Day Care Center; Family Child Care Home

Provider Qualifications

License *(specify):*

Health and Safety Code §§ 1596.90 – 1597.621

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Child Day Care Center: Title 22 CCR, §§101151-101239.2

Family Child Care Home: Title 22 CCR §§102351.1-102424

Other Standard *(specify):*

The administrator shall have the following qualifications:
1. Attainment of at least 18 years of age.
2. Knowledge of the requirements for providing the type of care and supervision children need and the ability to communicate with such children.
3. Knowledge of and ability to comply with applicable law and regulation.
4. Ability to maintain or supervise the maintenance of financial and other records.
5. Ability to establish the center's policy, program and budget.
6. Ability to recruit, employ, train, direct and evaluate qualified staff.

Verification of Provider Qualifications

Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
Adult Day Care Facility
Provider Qualifications
License *(specify):*
Health and Safety Code §§ 1500 - 1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
The administrator shall have the following qualifications:
1. Attainment of at least 18 years of age.
2. Knowledge of the requirements for providing the type of care and supervision needed by clients, including ability to communicate with such clients.
3. Knowledge of and ability to comply with applicable law and regulation.
4. Ability to maintain or supervise the maintenance of financial and other records.
5. Ability to direct the work of others, when applicable.
6. Ability to establish the facility's policy, program and budget.
7. Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff, if applicable to the facility.
8. A baccalaureate degree in psychology, social work or a related human services field and a minimum of one year experience in the management of a human services delivery system; or three years experience in a human services delivery system including at least one year in a management or supervisory position and two years experience or training in one of the following:
A. Care and supervision of recipients in a licensed adult day care facility, adult day support center or an adult day health care facility.
B. Care and supervision of one or more of the categories of persons to be served by the center.

The licensee must make provision for continuing operation and carrying out of the administrator's responsibilities during any absence of the administrator by a person who meets the qualification of an administrator.

Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
Respite Facility; Residential Facility: Family Home Agency(FHA): Adult Family Home(AFH)/Family Teaching Home(FTH)
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
AFH Title 17, CCR, §56088
Authorizes the FHA to issue a Certificate of Approval to each family home which has:
1. Completed the criminal record review ;
2. Been visited by the FHA and a determination ensuring safe and reasonable and the prospective providers experience, knowledge, cooperation, history and interest to become an approved family home.
3. Completed required orientation and training.
Other Standard *(specify):*
Welfare and Institutions Code 4689.1-4689.6 provides statutory authority for FHA.

FHA employs sufficient staff with the combined experience, training and education to perform the following duties:
1. Administration of the FHA;
2. Recruitment of family homes;
3. Training of FHA staff and family homes;
4. Ensuring an appropriate match between the needs and preferences of the consumer and the family home;
5. Monitoring of family homes;
6. Provision of services and supports to consumers and family homes which are consistent with the consumer's preferences and needs and the consumer's IPP; and
7. Coordination with the regional center and others.

In order to accomplish these duties, selection criteria for hiring purposes should include but not be limited to: education in the fields of social work, psychology, education of related areas; experience with persons with developmental disabilities; experience in program management, fiscal management and organizational development.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.
Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Has received Cardiopulmonary Resuscitation (CPR) and First Aid training from agencies offering such training, including, but not limited to, the American Red Cross; and has the skill, training, or education necessary to perform the required services.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:
Respite Facility; Residential Facility: Group Homes (Children Only)
Provider Qualifications
License *(specify):*
Health and Safety Code
§§ 1500-1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A

Other Standard *(specify):*
Title 22, CCR, § 84000-84808
Regulations adopted by DSS to specify requirements for licensure of Group Homes.
Administrator Qualifications:
1. Master's degree in a behavioral science, plus a minimum of one year of employment as a social worker in an agency serving children or in a group residential program for children;
2. Bachelor's degree, plus at least one year of administrative or supervisory experience (as above);
3. At least two years of college, plus at least two years administrative or supervisory experience (as above); or
4.Completed high school, or equivalent, plus at least three years administrative or supervisory experience (as above); and,
5. Criminal Records/Child Abuse Registry Clearance

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency

Provider Type:
Respite Facility; Residential Facility: Adult Residential Facilities (ARF)

Provider Qualifications

License *(specify):*
Health and Safety Code
§§ 1500 through 1567.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
Title 22, CCR, §§85000-85092: Establish licensing requirements for persons 18 years of age through 59 years of age; and persons 60 years of age and older by exception.

Administrator Qualifications
- At least 21 years of age;
- High school graduation or a GED;
- Complete a program approved by DSS that consists of 35 hours of classroom instruction
o 8 hrs. in laws, including resident's personal rights, regulations, policies, and procedural standards that impact the operations of adult residential facilities;
o 3 hrs. in business operations;
o 3 hrs. in management and supervision of staff;

o 5 hrs. in the psychosocial needs of the facility residents;
o 3 hrs. in the use of community and support services to meet the resident's needs;
o 4 hrs. in the physical needs of the facility residents;
o 5 hrs. in the use, misuse and interaction of drugs commonly used by facility residents;
o 4 hrs. on admission, retention, and assessment procedures;
- Pass a standardized test, administered by the Department of Social Services with a minimum score of 70%.
- Criminal Record/Child Abuse Registry Clearance.

Additional Administrator Qualifications may also include:
- Has at least one year of administrative and supervisory experience in a licensed residential program for persons
- with developmental disabilities, and
is one or more of the following:
(A) A licensed registered nurse.
(B) A licensed nursing home administrator.
(C) A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities.
(D) An individual with a bachelors degree or more advanced degree in the health or human services field and two years experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency

Provider Type:
Respite Agency

Provider Qualifications

License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
The agency director shall posses at a minimum:
1. A bachelor's degree and a minimum of 18 months experience in the management of a human

services delivery system, or;
2. Five years experience in a human services delivery system, including at least two years in a management or supervisory position.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency

Provider Type:
Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs

Provider Qualifications

License *(specify):*
Health and Safety Code §§1500-1569.87

Appropriate license DSS CCLD as to type of facility

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
Welfare and Institutions Code, § 4684.50 et seq.

The administrator must:
3. Complete the 35-houradministrator certification program pursuant to paragraph (1) of subdivision (c) of Section 1562.3 of the Health and Safety Code without exception,
4. Has at least one year of administrative and supervisory experience in a licensed residential program for persons with developmental disabilities, and is one or more of the following:
e. A licensed registered nurse.
f. A licensed nursing home administrator.
g. A licensed psychiatric technician with at least five years of experience serving individuals with developmental disabilities.
h. An individual with a bachelors degree or more advanced degree in the health or human services field and two years experience working in a licensed residential program for persons with developmental disabilities and special health care needs.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Department of Social Services – Community Care Licensing Division (DSS-CCLD) and regional centers.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):
Supported Employment (Enhanced Habilitation)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
• Supported employment services are defined in California Welfare and Institutions Code § 4851(n), (r), and (s). These services are received by eligible adults who are employed in integrated settings in the community. These individuals are unable to maintain this employment without an appropriate level of ongoing employment support services.
o The supported employment services provided are:
 Group Supported Employment (defined in California Welfare and Institutions Code §4851(r).
• Training and supervision of an individual while engaged in work in an integrated setting in the community.
• Recipients in group-supported employment receive supervision 100% of the time by the program and usually are paid according to productive capacity. A particular individual may be compensated at a minimum wage or at a rate less than minimum wage.

 Individual Supported Employment (defined in California Welfare and Institutions Code §4851(s).
• Training and supervision in addition to the training and supervision the employer normally provides to employees.
• Support services to ensure job adjustment and retention, provided on an individual basis in the community, as defined in California Welfare and Institutions Code §4851(q):
o Job development
o Job analysis
o Training in adaptive functional skills
o Social skill training
o Ongoing support services (e.g., independent travel, money management)
o Family counseling necessary to support the individual's employment
o Advocacy related to the employment, such as assisting individuals in understanding their benefits
o Advocacy or intervention to resolve problems affecting the consumer's work adjustment or retention.

• Recipients receiving individual services normally earn minimum wage or above and are on the employer's

payroll. Individuals receiving these services usually receive supervision 5-20% of the time by the program. The remainder of the time, the employer provides all supervision and training.
The above described services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 (29 USC Section 730) or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 USC 1401(16 and 17).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment (Enhanced Habilitation)

Provider Category:
Agency
Provider Type:
Supported Employment
Provider Qualifications
License *(specify):*
No state licensing category.

Federal/State Tax Exempt Letter.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Programs must initially meet the Department of Rehabilitation Program certification standards and be accredited by CARF within four years of providing services.
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Commission on Accreditation of Rehabilitation Facilities (CARF)
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Within four years at start-up; every one to three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Chore Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress, and minor repairs such as those which could be completed by a handyman. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore Services

Provider Category:
Individual
Provider Type:
Individual
Provider Qualifications

License *(specify):*
As appropriate for the services to be done.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Individual chore service providers shall possess the following minimum qualifications:
1. The ability to perform the functions required in the individual plan of care;
2. Demonstrate dependability and personal integrity.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Communication Aides

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Communication aides are those human services necessary to facilitate and assist persons with hearing, speech, or vision impairment to be able to effectively communicate with service providers, family, friends, co-workers, and the general public. The following are allowable communication aides, as specified in the recipient's plan of care:

1.Facilitators;
2.Interpreters and interpreter services;
3.Translators and translator services; and

Communication aide services include evaluation for communication aides and training in the use of communication aides.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Translator
Individual	Interpreter
Individual	Facilitators
Individual	Translator
Agency	Interpreter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Communication Aides

Provider Category:
Agency
Provider Type:
Translator
Provider Qualifications
License *(specify):*
No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. Fluency in both English and a language other than English;
2. The ability to read and write accurately in both English and a language other than English.
Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Communication Aides

Provider Category:
Individual
Provider Type:
Interpreter
Provider Qualifications
License *(specify):*
No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.
Certificate *(specify):*
N/A
Other Standard *(specify):*
1) Fluency in both English and a language other than English; and
2) The ability to read and write accurately in both English and a language other than English
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Communication Aides

Provider Category:
Individual
Provider Type:
Facilitators
Provider Qualifications
License *(specify):*

No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*
N/A

Other Standard *(specify):*
Qualifications and training as appropriate.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Communication Aides

Provider Category:
Individual

Provider Type:
Translator

Provider Qualifications

License *(specify):*
No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*
N/A

Other Standard *(specify):*
1. Fluency in both English and a language other than English;
2. The ability to read and write accurately in both English and a language other than English.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Communication Aides

Provider Category:
Agency
Provider Type:
Interpreter
Provider Qualifications
License *(specify):*
No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.
Certificate *(specify):*
N/A
Other Standard *(specify):*
1. Fluency in both English and a language other than English;
2. The ability to read and write accurately in both English and a language other than English.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Community-Based Training Service

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Community-based training service is a participant-directed service that allows recipients the opportunity to customize day services to meet their individualized needs. As determined by the person-centered individual program planning process, the service may include opportunities and assistance to: further the development or maintenance of employment and volunteer activities; pursue post secondary education; and increase recipients' ability to lead integrated and inclusive lives.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Community-based training services are limited to a maximum of 150 hours per quarter.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Community-Based Training Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community-Based Training Service

Provider Category:
Individual
Provider Type:
Community-Based Training Provider
Provider Qualifications

License *(specify):*
As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Providers of community-based training service shall be an adult who possesses the skill, training, and experience necessary to provide services in accordance with the individual program plan.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Dental Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Dental services will be provided to individuals age 21 and older and are defined and described in the approved State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. Dental services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit..
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Dentist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Dental Services

Provider Category:
Individual
Provider Type:
Dentist
Provider Qualifications
License *(specify):*
Business & Professions Code §§ 1600-1976

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:

Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Dental Board of California
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Biennially

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Environmental Accessibility Adaptations

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded form this benefit. All services shall be provided in accordance with applicable State or local building codes.

It may be necessary to make environmental modifications to an individual's home before he/she transitions from an institution to the community. Such modifications may be made while the person is institutionalized. Environmental modifications, included in the individual's plan of care, may be furnished up to 180 days prior to the individual's discharge from an institution. However, such modifications will not be considered complete until the date the individual leaves the institution and is enrolled in the waiver.

In the event an individual dies before the relocation can occur, but after the expenses have been incurred, the State will claim these expenses as administraive costs at the administrative FFP rate for services which would have been necessary for relocation to have taken place when the individual has:

- applied for waiver service; and

□ been found eligible for the waiver by the State (but for the person's status as an inpatient in an institution); and
□ died before the actual delivery of the waiver service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Contractor
Agency	Contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:
Contractor
Provider Qualifications
License *(specify):*
A current license, certification or registration with the State of California as appropriate for the type of modification being purchased.
Certificate *(specify):*
See "License"
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing as needed/required.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency
Provider Type:
Contractor
Provider Qualifications
License *(specify):*
A current license, certification or registration with the State of California as appropriate for the type of modification being purchased.
Certificate *(specify):*
See "License"
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing as needed/required.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Financial Management Service

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Financial Management Services (FMS) are designed to serve as a fiscal intermediary that performs financial transactions (paying for goods and services and/or processing payroll for adult consumers' or their families' workers included in the IPP) on behalf of the consumer. FMS is an important safeguard because it ensures that consumers are in compliance with Federal and state tax, labor, workers' compensation insurance and Medicaid regulations. The term "Financial Management Services" or "FMS" is used to distinguish this important participant direction support from the activities that are performed by intermediary organizations that function as Medicaid fiscal agents.

All FMS services shall:

1. Assist the family member or adult consumer in verifying worker citizenship status.
2. Collect and process timesheets of workers.
3. Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.
4. Track, prepare and distribute reports (e.g., expenditure) to appropriate individual(s)/entities.
5. Maintain all source documentation related to the authorized service(s) and expenditures.
6. Maintain a separate accounting for each participant's participant-directed funds.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
FMS services are available only for the following self-directed services: respite,transportation, community-based training service and skilled nursing.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Financial Management Services Provider
Agency	Financial Management Services Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Financial Management Service

Provider Category:
Individual

Provider Type:
Financial Management Services Provider

Provider Qualifications

License *(specify):*
Business license, as appropriate

Certificate *(specify):*
N/A

Other Standard *(specify):*
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Financial Management Service

Provider Category:
Agency
Provider Type:
Financial Management Services Provider
Provider Qualifications
License *(specify):*
Business license, as appropriate
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Non-Medical Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined in 42 CFR 440.170(a) (if applicable), and shall not replace them.

Transportation services under the waiver shall be offered in accordance with the individual's plan of care and shall include transportation aides and such other assistance as is necessary to assure the safe transport of the recipient. Private, specialized transportation will be provided to those individuals who cannot safely access and utilize public transportation services (when available.) Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

A regional center may offer vouchers to family members or adult consumers to allow the families and consumers to procure their own transportation services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Public Transit Authority
Agency	Transportation Company: Transportation Broker; Transportation Provider—Additional Component
Individual	Individual Transportation Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:
Public Transit Authority
Provider Qualifications
License *(specify):*
As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Welfare and Institutions Code Section 4648.3
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:
Transportation Company: Transportation Broker; Transportation Provider—Additional Component
Provider Qualifications
License *(specify):*
As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Welfare and Institutions Code Section 4648.3
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Individual
Provider Type:
Individual Transportation Provider
Provider Qualifications
License *(specify):*
Valid California driver's license

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Welfare and Institutions Code Section 4648.3
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for

the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nutritional Consultation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Nutritional consultation includes the provision of consultation and assistance in planning to meet the nutritional and special dietary needs of waiver participants. These services are consultive in nature and do not include specific planning and shopping for, or preparation of meals for waiver participants.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dietitian; Nutritionist
Individual	Dietitian; Nutritionist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nutritional Consultation

Provider Category:
Agency
Provider Type:
Dietitian; Nutritionist
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Dietician: Valid registration as a member of the American Dietetic Association
Other Standard *(specify):*
Nutritionist must possess a Master's Degree in one of the following:
a. Food and Nutrition;
b. Dietetics; or
c. Public Health Nutrition;
or is employed as a nutritionist by a county health department.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Nutritional Consultation

Provider Category:
Individual
Provider Type:
Dietitian; Nutritionist
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Dietician: Valid registration as a member of the American Dietetic Association
Other Standard *(specify):*
Nutritionist must possess a Master's Degree in one of the following:
a. Food and Nutrition;
b. Dietetics; or

c. Public Health Nutrition;
or is employed as a nutritionist by a county health department.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Optometric/Optician Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Optometric/Optician Services will be provided to individuals age 21 and older and are defined and described in the approved State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. Optometric/Optician services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit..

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Optometrist
Agency	Orthoptic Technician

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Optometric/Optician Services

Provider Category:
Agency
Provider Type:
Optometrist
Provider Qualifications
License *(specify):*
An optometrist is validly licensed as an optometrist by the California State Board of Optometry

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

California State Board of Optometry
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Biennially

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Optometric/Optician Services

Provider Category:
Agency
Provider Type:
Orthoptic Technician
Provider Qualifications
License *(specify):*
Business and Professions Codes in Chapter 7, Article 3

Sections 3041, 3041.3, 3056, 3057
Certificate *(specify):*
An orthoptic technician is validly certified by the American Orthoptic Council

Other Standard *(specify):*
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

American Orthoptic Council

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Personal Emergency Response Systems (PERS)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
PERS is a 24-hour emergency assistance service which enables the recipient to secure immediate assistance in the even of an emotional, physical, or environmental emergency. PERS are individually designed to meet the needs and capabilities of the recipient and includes training, installation, repair, maintenance, and response needs. The following are allowable:

1. 24-hour answering/paging;
2. Beepers;
3. Med-alert bracelets;
4. Intercoms;
5. Life-lines;
6. Fire/safety devices, such as fire extinguishers and rope ladders;
7. Monitoring services;
8. Light fixture adaptations (blinking lights, etc.);
9. Telephone adaptive devices not available from the telephone company;
10. Other electronic devices/services designed for emergency assistance.

PERS services are limited to those individuals who have no regular caregiver or companion for periods of time, and who would otherwise require extensive routine supervision. By providing immediate access to assistance,

PERS services prevent institutionalization of these individuals. PERS services will only be provided as a waiver service to individuals in a non-licensed environment.

All Items shall meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers where possible.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response Systems Provider
Individual	Contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:
Agency

Provider Type:
Personal Emergency Response Systems Provider

Provider Qualifications

License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
Certification / registration as appropriate for the type of system being purchased.

Other Standard *(specify):*
Providers shall be competent to meet applicable standards of installation, repair, and maintenance of emergency response systems. Providers shall also be authorized by the manufacturer to install, repair, and maintain such systems if such a manufacturer's authorization program exists.

Providers of human emergency response services shall possess or have employed persons who possess current licenses, certifications or registrations as necessary and required by the State of California for persons providing personal emergency response services.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:
Individual
Provider Type:
Contractor
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Certification / registration as appropriate for the type of system being purchased.
Other Standard *(specify):*
Providers shall be competent to meet applicable standards of installation, repair, and maintenance of emergency response systems. Providers shall also be authorized by the manufacturer to install, repair, and maintain such systems if such a manufacturer's authorization program exists.

Providers of human emergency response services shall possess or have employed persons who possess current licenses, certifications or registrations as necessary and required by the State of California for persons providing personal emergency response services.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Prescription Lenses and Frames

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Prescription Lens/Frames will be provided to individuals age 21 and older and are defined and described in the approved State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. Prescription lenses and frames will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dispensing Optician

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Prescription Lenses and Frames

Provider Category:
Agency
Provider Type:
Dispensing Optician
Provider Qualifications
License *(specify):*
Business and Professions Code §§ 2550-2560.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Registered as a dispensing optician by the Division of Allied Health Professions of the Medical Board of California
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Medical Board of California
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Biennially

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Psychology Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Psychology services will be provided to individuals age 21 and older and are defined and described in the approved State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. Psychology services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Clinical Psychologist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Psychology Services

Provider Category:
Agency
Provider Type:
Clinical Psychologist
Provider Qualifications
License *(specify):*
Business and Professions Code, §§2940-2948

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Board of Psychology
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Biennially

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Skilled Nursing

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Skilled Nursing services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

A regional center may offer vouchers to family members or adult consumers to allow the families and consumers to procure their own nursing services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse (RN)
Agency	Home Health Agency: RN or LVN
Individual	Licensed Vocational Nurse (LVN)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual
Provider Type:
Registered Nurse (RN)
Provider Qualifications
License *(specify):*
Business and Professions Code, §§ 2725-2742

Title 22, CCR, § 51067

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service

design.

Board of Registered Nursing, Licensing and regional centers
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Agency
Provider Type:
Home Health Agency: RN or LVN
Provider Qualifications
License *(specify):*
Title 22, CCR, §§ 74600 et. seq.

RN: Business and Professions Code, §§ 2725-2742
Title 22, CCR, § 51067

LVN: Business and Professions Code, §§ 2859-2873.7
Title 22, CCR, § 51069

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
Medi-Cal Certification using Medicare standards

Title 22, CCR, §§ 51069-51217.
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual

Provider Type:
Licensed Vocational Nurse (LVN)
Provider Qualifications
License *(specify):*
Business and Professions Code, §§ 2859-2873.7

Title 22, CCR, § 51069

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Board of Vocational Nursing and Psychiatric Technicians, Licensing and regional centers
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Medical Equipment and Supplies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. The repair, maintenance, installation, and

training in the care and use, of these items is also included. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design, and installation, and must meet Underwriter's Laboratory or Federal Communications Commission codes, as applicable. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealer where possible.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment Dealer

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency

Provider Type:
Durable Medical Equipment Dealer

Provider Qualifications

License *(specify):*
If applicable, a current license with the State of California as appropriate for the type of equipment or supplies being purchased.

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
If applicable, a current certification with the State of California as appropriate for the type of equipment or supplies being purchased.

Other Standard *(specify):*
Be authorized by the manufacturer to install, repair and maintain such systems if such a manufacturer's program exists.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Therapeutic Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized Therapeutic Services are services that provide physical, behavioral/social-emotional health, and or dental health care that have been adapted to accommodate the unique complexities presented by HCBS enrolled individuals. These complexities include requiring:

1. Additional time with the health care professional to allow for effective communication with patients to ensure the most effective treatment;
2. Additional time with the health care professional to establish the patient's comfort and receptivity to treatment to avoid behavioral reactions that will further complicate treatment;
3. Additional time for diagnostic efforts due to the masking effect of some developmental disabilities on health care needs;
4. Specialized expertise and experience of the health care professional in diagnosing health care needs that may be masked or complicated by a developmental disability;
5. Treatment to be provided in settings that are more conducive to the patient's ability to effectively receive treatment, either in specialized offices or facilities that offer better structured interaction with the patient or which may provide additional comfort and support which is needed to reduce patient anxiety that is related to his or her developmental disabilities.

All of these additional elements to Specialized Therapeutic Services are designed and proven effective in ensuring the health and safety of the patients who are enrolled in the HCBS waiver. They are also designed or adapted with specialized expertise, experience or supports to ensure that the impact of a person's developmental disability does not impede the practitioner's ability to effectively provide treatment. The design features and/or expertise levels required by these consumers have been developed through years of experience and are not available through existing State Plan services. These features are critical to maintain, preserve, or improve the health status and developmental progress of each individual who is referred to these Specialized Therapeutic Services.

Specialized Therapeutic Services include:

1. Oral Health Services: Diagnostic, Prophylactic, Restorative, Oral Surgery
2. Services for Maladaptive Behaviors/Social-Emotional Behavior Impairments (MB/SEDI) Due to/Associated with a Developmental Disability: Individual and group interventions and counseling
3. Physical Health Services: Physical Therapy, Occupational Therapy, Speech Therapy, Respiratory Therapy, Diagnostic and Treatment, Physician Services, Nursing Services, Diabetes Self-Management

The need for a Specialized Therapeutic Service must be identified in the Individual Program Plan, also known as a Plan of Care, and is to be provided only when the individual's regional center planning team has:

1. Determined the reason why other generic or State Plan services can not/do not meet the unique oral health, behavioral/social-emotional health, physical health needs of the consumer as a result of his/her developmental disability and the impact of the developmental disability on the delivery of therapeutic services;
2. Determined that a provider with specialized expertise/knowledge in serving individuals with developmental disabilities is needed, i.e., a provider of State Plan services does not have the appropriate qualifications to provide the service;
3. Determined that the individual's needs cannot be met by a State Plan provider delivering routine State Plan services;
4. Determined that the Specialized Therapeutic Service is a necessary component of the overall Plan of Care that is needed to avoid institutionalization; and
5. Consulted with a Regional Center clinician.

The need to continue the Specialized Therapeutic Service will be evaluated during the mandatory annual review of the individual's IPP in order to determine if utilization is appropriate and progress is being made as a result of the service being provided.

The following specify the differences between Specialized Therapeutic Services and services available under the approved State Plan:

1. Provider qualifications.
2. The scope (what is provided).
3. The services will be offered either at the consumer's home, the program site, or when appropriate, the provider's site.

Providers of Specialized Therapeutic Services must hold a current State license or certificate to practice in the respective clinical field for which they are vendored and have at least one year of experience working providing direct care in the field of licensure with persons with developmental disabilities, validation of which must be obtained by the regional center prior to vendorization and maintained in the regional center vendor file. This expanded qualification requirement differentiates providers of Specialized Therapeutic Services from State Plan providers. These providers include physicians/surgeons, nurse practitioners, registered nurses, licensed vocational nurses, psychologists, social workers, speech therapists, physical therapists, physical therapy assistants, dental hygienists, dentists, and marriage and family therapists. Certified occupational therapists, occupational therapy assistants, respiratory therapists, and chemical addiction counselors are also included.

Scope of Services: When provided as a home and community-based service, a Specialized Therapeutic Service may require one or more of the following if determined critical to the ongoing maintenance of the oral care, health care, or behavioral/social-emotional health care of the individuals in his/her residence or program environment. This expansion of the scope of the Specialized Therapeutic Service differentiates it from other State Plan services. These are provided as a component of an allowable specialized therapeutic service, are billed to the Waiver as part of the specialized therapeutic service being provided, and are designed to improve the consumer or caregiver's capacity to effectively access services, interpret care instructions, or provide care as directed by the clinical professional. Each of these will be provided only if it is directly associated with a specialized therapeutic service provided to an individual and are included in an approved plan of care.

1. Family support and counseling - Critical to a full understanding of the impact of involved developmental disabilities on the presenting health care need and effective treatment. The health care practitioner delivering the health, dental, or behavioral/social-emotional health specialized services may need to provide family support and/or counseling, as well as consumer training and consultation with other physicians or involved professionals, in order to ensure the proper understanding of the treatment and support in the person's home environment and that it is critical to effective treatment of people with developmental disabilities;
2. Provider travel necessary to deliver the service - If cost-effective and necessary, the cost of travel may be included in order to allow the provider to provide the care at a location that is necessary due to the disabilities of the individual;
3. Consultation with other involved professionals in meeting the physical, behavioral/social-emotional health and/or dental health needs of the consumer through specialized therapeutic services. This allows the clinical provider of specialized therapeutic services to properly involve other professional care givers who deliver services in accordance with the individual's plan of care;
4. Consumer training - at times the individual will require additional training by a specialized therapeutic

service provider to maintain or enhance the long-term impact of the oral, behavioral/social-emotional health, or health care treatment provided. An appropriately licensed or certified provider, as defined above, will provide this training.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Dentist, Dental Hygienist, Psychologist, Marriage & Family Therapist, Social Worker, Chemical Addiction, Physician/Surgeon, Speech Therapist
Individual	Dentist, Dental Hygienist, Psychologist, Marriage & Family Therapist, Social Worker, Chemical Addiction, Physician/Surgeon, Speech Therapist
Agency	Occupational Therapist, Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, Respiratory Therapist, RN, LVN, Nurse Practitioner
Individual	Occupational Therapist, Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, Respiratory Therapist, RN, LVN, Nurse Practitioner

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Therapeutic Services

Provider Category:

Agency

Provider Type:

Dentist, Dental Hygienist, Psychologist, Marriage & Family Therapist, Social Worker, Chemical Addiction, Physician/Surgeon, Speech Therapist

Provider Qualifications

License *(specify):*

Business and Professions Code:

Dentist: §1628- 1635
Dental Hygienist: §1766 & 1768
Psychologist: §2940-2946
Marriage & Family Therapist: §4986.2
Social Worker: §4996.1 – 4996.2
Physician/Surgeon: §2080-2096
Speech Therapist: §2532.1-2532.6

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Chemical Addition Counselor - certified in accordance with Title 9 CCR § 9846-13075

Physicians and Surgeons: Business and Professions Code, §2080-2085

Other Standard *(specify):*
Providers of Specialized Therapeutic Services must hold a current State license or certificate to practice in the respective clinical field for which they are vendored and have at least one year of experience working providing direct care in the field of licensure with persons with developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Therapeutic Services

Provider Category:
Individual

Provider Type:
Dentist, Dental Hygienist, Psychologist, Marriage & Family Therapist, Social Worker, Chemical Addiction, Physician/Surgeon, Speech Therapist

Provider Qualifications

License *(specify):*
Business and Professions Code:

Dentist: §1628- 1635
Dental Hygienist: §1766 & 1768
Psychologist: §2940-2946
Marriage & Family Therapist: §4986.2
Social Worker: §4996.1 – 4996.2
Physician/Surgeon: §2080-2096
Speech Therapist: §2532.1-2532.6

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
Chemical Addition Counselor - certified in accordance with Title 9 CCR § 9846-13075

Physicians and Surgeons: Business and Professions Code, §2080-2085

Other Standard *(specify):*
Providers of Specialized Therapeutic Services must hold a current State license or certificate to practice in the respective clinical field for which they are vendored and have at least one year of experience working providing direct care in the field of licensure with persons with developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:

Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Therapeutic Services

Provider Category:
Agency
Provider Type:
Occupational Therapist, Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, Respiratory Therapist, RN, LVN, Nurse Practitioner
Provider Qualifications
License *(specify):*
Occupational Therapist and Assistant: §2570.6
Physical Therapist: §2636.5
Physical Therapy Assistant: §2655
Respiratory Therapist: §3733-3737
RN § 2725-2742
LVN § 2859-2873.7
Nurse Practitioner: §2834-2837

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*

Other Standard *(specify):*
Providers of Specialized Therapeutic Services must hold a current State license or certificate to practice in the respective clinical field for which they are vendored and have at least one year of experience working providing direct care in the field of licensure with persons with developmental disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Therapeutic Services

Provider Category:
Individual
Provider Type:
Occupational Therapist, Occupational Therapy Assistant, Physical Therapist, Physical Therapy Assistant, Respiratory Therapist, RN, LVN, Nurse Practitioner

Provider Qualifications

License *(specify):*
Occupational Therapist and Assistant: §2570.6
Physical Therapist: §2636.5
Physical Therapy Assistant: §2655
Respiratory Therapist: §3733-3737
RN § 2725-2742
LVN § 2859-2873.7
Nurse Practitioner: §2834-2837

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*

Other Standard *(specify):*
Providers of Specialized Therapeutic Services must hold a current State license or certificate to practice in the respective clinical field for which they are vendored and have at least one year of experience working providing direct care in the field of licensure with persons with developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Speech, Hearing and Language Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Speech, Hearing and Language services will be provided to individuals age 21 and older and are defined and described in the approved State plan for individuals under the age of 21. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. Speech, Hearing and

Language services will supplement and not supplant services available through the approved Medicaid State plan or the EPSDT benefit.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Speech Pathologist
Agency	Audiology
Agency	Hearing and Audiology Facilities
Individual	Audiology
Agency	Speech Pathologist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Speech, Hearing and Language Services

Provider Category:
Individual

Provider Type:
Speech Pathologist

Provider Qualifications

License *(specify):*
Business & Professions Code §§ 2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Biennially.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Speech, Hearing and Language Services

Provider Category:
Agency
Provider Type:
Audiology
Provider Qualifications
License *(specify):*
Business & Professions Code §§ 2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Biennially if non-dispensing audiologist; annually if dispensing.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Speech, Hearing and Language Services

Provider Category:
Agency
Provider Type:
Hearing and Audiology Facilities
Provider Qualifications
License *(specify):*
No state licensing category.

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*

An audiology facility:
1. Employs at least one audiologist who is licensed by the Speech Pathology and Audiology Examining Committee of the Medical Board of California; and
2. Employs individuals, other than 1. above, who perform services, all of whom shall be:
• Licensed audiologists; or
• Obtaining required professional experience, and whose required professional experience application has been approved by the Speech Pathology and Audiology Examining Committee of the Medical Board of California.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Biennially.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Speech, Hearing and Language Services

Provider Category:
Individual

Provider Type:
Audiology

Provider Qualifications

License *(specify):*
Business & Professions Code §§ 2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.

Certificate *(specify):*
N/A

Other Standard *(specify):*
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Biennally if non-dispensing audiologist; annually if dispensing.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Speech, Hearing and Language Services

Provider Category:
Agency
Provider Type:
Speech Pathologist
Provider Qualifications
License *(specify):*
Business & Professions Code §§ 2532-2532.8

As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Biennially.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Transition/Set Up Expenses

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Transition/Set Up Expenses are one-time, non-recurring set-up expenses to assist individuals who are transitioning from an institution to their own home. These expenses fund some of the initial set-up costs that are associated with obtaining and securing an adequate living environment and address the individual's health and safety needs when he or she enters a new living environment.

"Own home" is defined as any dwelling, including a house, apartment, condominium, trailer, or other lodging that is owned, leased, or rented by the individual.

This service includes necessary furnishings, household items and services that an individual needs for successful transition to community living and may include:
 Security deposits that are required to obtain a lease on an apartment or home;
 Moving expenses;
 Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy;
 Set up fees or non-refundable deposits for utilities (telephone, electricity, heating by gas);
 Essential furnishings to occupy and use a community domicile, such as a bed, table, chairs, window blinds, eating utensils, food preparation items, etc.

These services exclude:

 Items designed for diversionary/recreational/entertainment purposes, such as hobby supplies, television, cable TV access, or VCRs and DVDs.
 Room and board, monthly rental or mortgage expense, regular utility charges, household appliances, and food.

Items purchased through this service are the property of the individual receiving the service and the individual takes the property with him/her in the event of a move to another residence.

Some of these expenses may be incurred before the individual transitions from an institution to the community. In such cases, the Transition/Set Up expenses incurred while the person was institutionalized are not considered complete until the date the individual leaves the institution and is enrolled in the waiver. Transition/Set Up expenses included in the individual's plan of care may be furnished up to 180 days prior to the individual's discharge from an institution. However, such expenses will not be considered complete until the date the individual leaves the institution and is enrolled in the waiver.

In the event an individual dies before the relocation can occur, but after the expenses have been incurred, the State will claim these expenses as administraive costs at the administrative FFP rate for services which would have been necessary for relocation to have taken place when the individual has:

 applied for waiver service; and
 been found eligible for the waiver by the State (but for the person's status as an inpatient in an institution); and
 died before the actual delivery of the waiver service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual (landlord, property management)
Agency	Public Utility Agency, Retail and Merchandise Company, Health and Safety Agency, Moving Company

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transition/Set Up Expenses

Provider Category:
Individual
Provider Type:
Individual (landlord, property management)
Provider Qualifications
License *(specify):*
As appropriate, a business license as required by the local jurisdiction where the business is located
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transition/Set Up Expenses

Provider Category:
Agency
Provider Type:
Public Utility Agency, Retail and Merchandise Company, Health and Safety Agency, Moving Company
Provider Qualifications
License *(specify):*
As appropriate, a business license as required by the local jurisdiction where the business is located.
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as

applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Vehicle Modifications and Adaptations

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Vehicle adaptations are devices, controls, or services which enable recipients to increase their independence or physical safety, and which allow the recipient to live in their home. The repair, maintenance, installation, and training in the care and use, of these items are included. Vehicle adaptations must be performed by the manufacturer's authorized dealer. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealer where possible.

The following types of adaptations to the vehicle are allowable:

1. Door handle replacements;
2. Door widening;
3. Lifting devices;
4. Wheelchair securing devices;
5. Adapted seat devices;
6. Adapted steering, acceleration, signaling, and braking devices; and
7. Handrails and grab bars

Adaptations to vehicles shall be included if, on an individual basis, the cost effectiveness of vehicle adaptations, relative to alternative transportation services, is established. Adaptations to vehicles are limited to vehicles owned by the recipient, or the recipient's family and do not include the purchase of the vehicle itself.

The recipient's family includes the recipient's biological parents, adoptive parents, stepparents, siblings, children, spouse, domestic partner (in those jurisdictions in which domestic partners are legally recognized), or a person who is legal representative of the recipient.

Vehicle adaptations will only be provided when they are documented in the individual plan of care and when there is a written assessment by a licensed Physical Therapist or a registered Occupational Therapist.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vehicle Modification and Adaptation
Individual	Vehicle Modification and Adaptation

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications and Adaptations

Provider Category:
Agency
Provider Type:
Vehicle Modification and Adaptation
Provider Qualifications
License *(specify):*
No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.
Certificate *(specify):*
Registration with the California Department of Consumer Affairs, Bureau of Automotive Repairs.
Other Standard *(specify):*
Providers shall be competent to meet applicable standards of installation, repair, and maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible.
Verification of Provider Qualifications
Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.
Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications and Adaptations

Provider Category:
Individual

Provider Type:
Vehicle Modification and Adaptation

Provider Qualifications

License *(specify):*
No state licensing category.

An appropriate business license as required by the local jurisdiction for the adaptations to be completed.

Certificate *(specify):*
Registration with the California Department of Consumer Affairs, Bureau of Automotive Repairs.

Other Standard *(specify):*
Providers shall be competent to meet applicable standards of installation, repair, and maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible.

Verification of Provider Qualifications

Entity Responsible for Verification:
Regional centers, through the vendorization process, verify providers meet requirements/qualifications outlined in Title 17, CCR, § 54310 including the following, as applicable: any license, credential, registration, certificate, permit, or academic degree required for the performance or operation of the service; the staff qualifications and duty statements; and service design.

Frequency of Verification:
Verified upon application for vendorization and ongoing thereafter through oversight and monitoring activities.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Regional centers are responsible for providing case management services to waiver participants. Case management includes:
• Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services;
• Development (and periodic revision) of an individual program plan (IPP) that is based on the information collected through the assessment;

• Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services;
• Monitoring and follow-up activities to ensure the IPP is implemented effectively and adequately addresses the consumer's needs.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The types of positions requiring fingerprint clearance:
1. All staff persons, employees or volunteers who have contact with consumers in community care facilities licensed by the Department of Social Services.
a. Any person other than a consumer residing in the facility.
b. Adults responsible for administration or direct supervision of staff.
c. If the applicant is a firm, partnership, association, or corporation, the chief executive officer or other person serving in like capacity.
d. Additional officers of the governing body of the applicant, or other persons with a financial interest in the applicant.

Caregiver background checks are conducted by Department of Social Services (DSS)/Community Care Licensing Division (CCL.) The licensing program protects consumers by screening out unqualified applicants and individuals associated with facilities. DSS/CCL implements this protection by requiring that individuals receive a fingerprint-based check of their criminal history from both the California Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). The background check for individuals associated with children's facilities also includes a required check with the Child Abuse Central Index maintained at the DOJ. Certain serious crimes specifically exclude someone from working or being in a facility. For other crimes, if criminal history information indicates a conviction, the DSS/CCL evaluates the individual's history to determine if the individual can be involved in a licensed facility. DSS/CCL investigates the circumstances of any arrest to determine if the allegations can be substantiated according to licensing standards. Also, DSS/CCL can take administrative action against an individual associated with a licensed facility when there is an allegation of rights violations that involve abuse. Based on a preponderance of evidence in this situation, an individual could be excluded from working in a licensed facility. DSS maintains a database of excluded individuals which is checked, in addition to the DOJ and FBI criminal history checks, as part of the screening process.

Further, various professions (e.g., nurses) licensed under the provisions of the California Business and Professions Code must undergo a criminal record review as a condition of licensure and license renewal. Under this waiver, licensed individuals may provide several types of services including skilled nursing, behavior intervention services, and specialized therapeutic services. Criminal record reviews are performed by the applicable licensing authority. The regional center verifies that licensed individuals selected by the participant are properly licensed.

Lastly, all applicants for vendorization shall disclose the information required by 42 CFR §§455.104, 445.105 and 455.106. This disclosure information includes any person who, as applicant, has ownership or control interest in the applicant, or is an agent, director, officer or managing employee of the applicant who has: been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of an elder or dependent adult or child, or in any connection with the interference with or obstruction of any investigation into health care related fraud or abuse; been found liable for fraud or abuse in any civil proceeding; or entered into a settlement in lieu of conviction for fraud or abuse in any government

program. These disclosure and verification activities will take place at the time or application and periodically thereafter if the applicant is vendored.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- **No. The State does not conduct abuse registry screening.**
- **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Adult Residential Facility (ARF)	
Foster Family Home (FFH)	
Adult Residential Facilities for Persons with Special Health Care Needs. (ARFPSHN)	
Residential Care for the Elderly (RCFE)	
Small Family Homes (SFH) (Children Only)	
Group Homes (GH) (Children Only)	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Residential settings can include facilities that may house four or more individuals that are unrelated to the service provider. In these instances, the person-centered planning team must determine that the setting is appropriate to the individual's need for independence, choice and community integration. The determination will take into consideration the provision of the following:

1. Private or semi-private bedrooms shared by no more than two persons with personal décor. The choice of residential settings, including making decisions regarding sharing a bedroom, is made during the person-centered planning process.
2. Private or semi-private bathrooms. The residence must have enough bathroom space to ensure residents' privacy for personal hygiene, dressing, etc.
3. Common living areas or shared common space for interaction between residents, and residents and

their guests.
4. Residents must have access to a kitchen area at all times.
5. Residents' opportunity to make decisions on their day-to-day activities, including visitors and when and what to eat, in their home and in the community.
6. Services which meet the needs of each resident.
7. Assurance of residents rights: a) to be treated with respect; b) choose and wear their own clothes; c) have private space to store personal items; d) have private space to visit with friends and family; e) use the telephone with privacy; f) choose how and with whom to spend free time; and h) have opportunities to take part in community activities of their choice.

Residential settings that contain multiple independent living units (e.g. apartments) are considered home -like settings for the purposes of this Waiver.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Residential Facility (ARF)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Homemaker	☐
Financial Management Service	☐
Vehicle Modifications and Adaptations	☐
Non-Medical Transportation	☐
Optometric/Optician Services	☐
Communication Aides	☐
Home Health Aide	☐
Speech, Hearing and Language Services	☐
Specialized Medical Equipment and Supplies	☐
Chore Services	☐
Community-Based Training Service	☐
Environmental Accessibility Adaptations	☐
Prescription Lenses and Frames	☐
Personal Emergency Response Systems (PERS)	☐
Specialized Therapeutic Services	☐
Dental Services	☐
Respite Care	☑
Community Living Arrangements	☑
Skilled Nursing	☐
Nutritional Consultation	☐
Day Service	☐

Waiver Service	Provided in Facility
Supported Employment (Enhanced Habilitation)	☐
Prevocational Services	☐
Psychology Services	☐
Transition/Set Up Expenses	☐
Behavioral Intervention Services	☑

Facility Capacity Limit:

Capacity is specified in license; typically house 4-6 individuals

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Foster Family Home (FFH)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Homemaker	☐
Financial Management Service	☐

Waiver Service	Provided in Facility
Vehicle Modifications and Adaptations	☐
Non-Medical Transportation	☐
Optometric/Optician Services	☐
Communication Aides	☐
Home Health Aide	☐
Speech, Hearing and Language Services	☐
Specialized Medical Equipment and Supplies	☐
Chore Services	☐
Community-Based Training Service	☐
Environmental Accessibility Adaptations	☐
Prescription Lenses and Frames	☐
Personal Emergency Response Systems (PERS)	☐
Specialized Therapeutic Services	☐
Dental Services	☐
Respite Care	☐
Community Living Arrangements	☑
Skilled Nursing	☐
Nutritional Consultation	☐
Day Service	☐
Supported Employment (Enhanced Habilitation)	☐
Prevocational Services	☐
Psychology Services	☐
Transition/Set Up Expenses	☐
Behavioral Intervention Services	☑

Facility Capacity Limit:

Capacity specified in license; typically 2-3 individuals

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑

Standard	Topic Addressed
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Residential Facilities for Persons with Special Health Care Needs. (ARFPSHN)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Homemaker	☐
Financial Management Service	☐
Vehicle Modifications and Adaptations	☐
Non-Medical Transportation	☐
Optometric/Optician Services	☐
Communication Aides	☐
Home Health Aide	☐
Speech, Hearing and Language Services	☐
Specialized Medical Equipment and Supplies	☐
Chore Services	☐
Community-Based Training Service	☐
Environmental Accessibility Adaptations	☐
Prescription Lenses and Frames	☐
Personal Emergency Response Systems (PERS)	☐
Specialized Therapeutic Services	☐
Dental Services	☐
Respite Care	☐
Community Living Arrangements	☑
Skilled Nursing	☐

Waiver Service	Provided in Facility
Nutritional Consultation	☐
Day Service	☐
Supported Employment (Enhanced Habilitation)	☐
Prevocational Services	☐
Psychology Services	☐
Transition/Set Up Expenses	☐
Behavioral Intervention Services	☐

Facility Capacity Limit:

Maximum is five

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Care for the Elderly (RCFE)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Homemaker	☐
Financial Management Service	☐
Vehicle Modifications and Adaptations	☐
Non-Medical Transportation	☐
Optometric/Optician Services	☐
Communication Aides	☐
Home Health Aide	☐
Speech, Hearing and Language Services	☐
Specialized Medical Equipment and Supplies	☐
Chore Services	☐
Community-Based Training Service	☐
Environmental Accessibility Adaptations	☐
Prescription Lenses and Frames	☐
Personal Emergency Response Systems (PERS)	☐
Specialized Therapeutic Services	☐
Dental Services	☐
Respite Care	☑
Community Living Arrangements	☑
Skilled Nursing	☐
Nutritional Consultation	☐
Day Service	☐
Supported Employment (Enhanced Habilitation)	☐
Prevocational Services	☐
Psychology Services	☐
Transition/Set Up Expenses	☐
Behavioral Intervention Services	☑

Facility Capacity Limit:

Capacity is specified in license; typically house 6-50 individuals

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑

Standard	Topic Addressed
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Small Family Homes (SFH) (Children Only)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Homemaker	☐
Financial Management Service	☐
Vehicle Modifications and Adaptations	☐
Non-Medical Transportation	☐
Optometric/Optician Services	☐
Communication Aides	☐
Home Health Aide	☐
Speech, Hearing and Language Services	☐
Specialized Medical Equipment and Supplies	☐
Chore Services	☐
Community-Based Training Service	☐
Environmental Accessibility Adaptations	☐
Prescription Lenses and Frames	☐
Personal Emergency Response Systems (PERS)	☐
Specialized Therapeutic Services	☐
Dental Services	☐

Waiver Service	Provided in Facility
Respite Care	☑
Community Living Arrangements	☑
Skilled Nursing	☐
Nutritional Consultation	☐
Day Service	☐
Supported Employment (Enhanced Habilitation)	☐
Prevocational Services	☐
Psychology Services	☐
Transition/Set Up Expenses	☐
Behavioral Intervention Services	☑

Facility Capacity Limit:

Maximum is six

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Group Homes (GH) (Children Only)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Homemaker	☐
Financial Management Service	☐
Vehicle Modifications and Adaptations	☐
Non-Medical Transportation	☐
Optometric/Optician Services	☐
Communication Aides	☐
Home Health Aide	☐
Speech, Hearing and Language Services	☐
Specialized Medical Equipment and Supplies	☐
Chore Services	☐
Community-Based Training Service	☐
Environmental Accessibility Adaptations	☐
Prescription Lenses and Frames	☐
Personal Emergency Response Systems (PERS)	☐
Specialized Therapeutic Services	☐
Dental Services	☐
Respite Care	☑
Community Living Arrangements	☑
Skilled Nursing	☐
Nutritional Consultation	☐
Day Service	☐
Supported Employment (Enhanced Habilitation)	☐
Prevocational Services	☐
Psychology Services	☐
Transition/Set Up Expenses	☐
Behavioral Intervention Services	☑

Facility Capacity Limit:

Capacity is specified in license; typically house 4-6 individuals

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑

Standard	Topic Addressed
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ○ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

  Relatives may provide any waiver service as long as the relative possesses the skill, training and/or education to provide the service and that the individual meets the provider qualifications specified for that service. Relatives are required to the same vendorization requirements that all providers must adhere to, as well as being subject to the monitoring requirements for the specified service.

- **Other policy.**

  Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The vendorization process, including provider qualifications, is referenced in the California Code of Regulations, Title 17, Division 2, Chapter 3, Subchapter 2. All applicants who meet the required provider qualifications are eligible to provide waiver services. Information on the vendorization process and provider qualifications is continuously available via the internet at www.dds.ca.gov.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of licensed providers that initially meet all required standards prior to furnishing waiver services. Numerator = number of providers

that initially meet all required standards prior to furnishing waiver services; denominator = number of all providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Vendor Master File records indicate regional center verification of provider qualifications

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Regional Centers	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of providers licensed by the Department of Social Services (DSS) reviewed annually. Numerator = number of DSS licensed providers reviewed annually; denominator = total number of providers licensed by DSS that require annual review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Facilities Automated System

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Department of Social Services (DSS)	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Department of Social Services (DSS)	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: DHCS, DSS and DDS meet quarterly to review issues concerning DSS licensed facilities

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of non-licensed/non-certified providers that initially meet all required standards prior to furnishing waiver services. Numerator = number of providers that initially meet all required standards prior to furnishing waiver services; denominator = number of all providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Vendor Master File records indicate regional center verification of provider qualifications

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Regional Centers	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of direct support professionals (DSPs) that successfully complete 70 hours of competency based training within two years of hire. Numerator = number of DSPs who successfully complete the training; denominator = number of DSPs who attempt the training.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DSP Training Program Annual Report

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Individual issues identified during the State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews are documented in monitoring reports which are sent to the regional centers with the State's recommendations for resolution. Regional centers are responsible for developing and implementing plans for correction responsive to the State's recommendations. These plans are evaluated and approved by DHCS and DDS before the final monitoring report, containing the State's recommendations and corrective actions taken, are issued to the regional centers and forwarded to CMS.

All deficiencies noted during DSS inspections of licensed facilities result in the development of a plan of correction. All plans of correction require follow-up, which may include a repeat inspection, to ensure the plan was successfully completed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Regional Centers, DSS	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- [ ] **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.
- [ ] **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.
- [ ] **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.
- [ ] **Other Type of Limit.** The State employs another type of limit.
  Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Program Plan (IPP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [ ] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)

☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

The minimum requirement is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis.

☐ **Social Worker.**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

a) the supports and information made available – The service plan, commonly referred to as the individual program plan (IPP), is developed through a process of individualized needs determination, which includes gathering information from providers of services and supports, and is prepared jointly by the planning team. Each individual is paired with a case manager to assist in the IPP development. Information available for supporting recipients in the IPP process includes but is not limited to the following documents, all of which are available using the links below or through the DDS website at www.dds.ca.gov:
1. "Individual Program Plan Resource Manual" - This resource manual is designed to facilitate the adoption of the values that lead to person-centered individual program planning. It is intended for use by all those who participate in person-centered planning. It was developed with extensive input from service recipients, families, advocates and providers of service and support.
2. "Person Centered Planning" - This publication consists of excerpts taken from the Individual Program Plan Resource Manual to provide recipients and their families information regarding person-centered planning.
3. "From Conversations to Actions Using the IPP" - This booklet shares the real life stories of how recipients can set their goals and objectives and work through the IPP process to achieve them.
4. "From Process to Action: Making Person-Centered Planning Work" - This guide provides a quick look at questions that can help a planning team move the individual program plan from process to action focusing on the person and the person's dreams for a preferred future.
b) The participant’s authority to determine who is included in the process - The IPP planning team, at a minimum,

consists of the recipient and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, and an authorized regional center representative. With the consent of the recipient/conservator, other individuals, may receive notice of the meeting and participate.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The IPP is developed by the planning team through a process of individualized needs determination. The planning team, at a minimum, consists of the HCBS Waiver recipient (consumer) and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, and the regional center case manager. With the consent of the consumer/conservator, other individuals, including service providers, may receive notice of the meeting and participate in the development of the IPP.

The IPP development process includes gathering information and conducting assessments (ex. the Client Development Evaluation Report or CDER) to determine the life goals, capabilities and strengths, preferences, barriers, and concerns or problems of the consumer. For children, this process includes a review of the strengths, preferences, and needs of the child and the family unit as a whole. Assessments are conducted to identify potential health, behavioral or safety risks that may require the development of mitigation strategies. Information is obtained from the consumer, his or her parents and other family members, his or her friends, advocates, providers of services and supports, and other agencies. The assessment process reflects awareness of, and sensitivity to, the lifestyle and cultural background of the consumer and the family.

Utilizing information obtained during the assessment process, the IPP is prepared jointly by the planning team. Decisions regarding goals, objectives, needed services and providers of services are made with the agreement of the planning team. The goals included in the IPP, and objectives to implement those goals, are based on the consumer’s needs, preferences and life choices. The IPP identifies the providers responsible for implementing services that address the agreed upon goals and objectives. The IPP must also include a schedule of all services purchased by the regional center or obtained from generic resources. The receipt of these services is coordinated during the planning process to ensure any needed services available through generic resources are provided prior to accessing available waiver services.

The IPP must be reviewed (at least annually) and modified by the planning team when necessary. The annual review of the IPP will often include the development of a new IPP. In some cases a new IPP is completed biennially or triennially. If a new IPP is not completed annually, case managers will continue to use the DDS “Standardized Annual Review” form to document the annual review of the consumer’s IPP, CDER and health status. If new services or supports are needed, the IPP will be amended to include the new services or supports. The planning team members will sign the “Standardized Annual Review” form to document that the remainder of the IPP remains appropriate to meet the consumer’s needs. If no new services or supports are required, the planning team will indicate that the IPP remains appropriate to meet the consumer’s needs. Regardless of the planned schedule for review and modification of the IPP, a review of the IPP can be requested at any time and will be modified in response to the consumer’s needs upon agreement of the planning team. Further information on monitoring the implementation of the service pan is contained in Appendix D-2(a).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

As noted above, the IPP person-centered planning process includes an assessment of risk and identification of mitigation strategies as necessary. With input from the State's independent risk management contractor, DDS distributed a tool that can be used to aid the IPP planning team in identifying risk factors and developing interventions to minimize risks. Individual risk and safety considerations are identified during the person-centered planning process. Potential interventions that promote independence and safety with the informed involvement of the participant are included in the IPP when the planning team agrees that it is an identified need.

For consumers that are supported in their own residence, services are available to assist in responding to emergencies or other unusual situations. Available services include 24-hour emergency assistance, such as direct service in response to calls for assistance. Additionally, support to become aware of and effectively use the police, fire, and emergency help available in the community is available. Services may also include assisting and facilitating the consumer's efforts to acquire, use, and maintain devices needed to summon immediate assistance when threats to health, safety, and well-being occur. The IPP planning team makes decisions regarding which, if any, of these services will be included in the IPP based on the consumer's needs and preferences.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The case manager informs the consumer and/or his or her legal representative of qualified providers of services determined necessary through the IPP planning process. Consumers may meet with qualified providers prior to the final decision regarding providers to be identified in the service plan. The consumer's choice of providers includes consideration of, among other things, the provider's ability to deliver quality services or supports that can accomplish all or part of the person's program plan and the provider's success in achieving the objectives set forth in the consumer's IPP.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

As part of the State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews, DHCS in conjunction with DDS reviews a random, representative sample of consumer IPPs to ensure all service plan requirements have been met.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

Regional Centers

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Regional center case managers are responsible for monitoring the implementation of all consumer IPPs. At least annually, all IPPs are reviewed to determine that planned services have been provided, that sufficient progress has been made on the consumers' goals and objectives, and that consumers and families are satisfied with the individual program plan and its implementation.

For consumers who reside in community, out-of-home settings (e.g. residential community care facilities, adult family homes, supported or independent living settings), quarterly face-to-face monitoring is required to monitor the consumer's health, safety and well-being, asses the effectiveness of services and monitor progress in meeting the identified goals.

Further, as part of the State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews, DHCS in conjunction with DDS reviews a random, representative sample of consumer IPPs to ensure IPP implementation monitoring is being completed.

b. **Monitoring Safeguards.** *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**

i. **Sub-Assurances:**

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of reviewed individual program plans (IPPs) that adequately addressed the consumers' assessed needs. Numerator = number of consumer IPPs reviewed that addressed all assessed needs. Denominator = total number of consumer IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct

		proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of consumer IPPs that addressed the consumer's identified health needs and safety risks. Numerator = number of consumer IPPs reviewed that addressed the consumers' identified health needs and safety risks. Denominator = total number of consumer IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Representative Sample; Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused	

	follow-up reviews are conducted annually or more frequently as needed.

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of consumer IPPs that addressed the consumer's goals. Numerator = number of consumer IPPs reviewed that addressed the consumers' goals. Denominator = total number of consumer IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Representative Sample; Confidence Interval = 3.01

		Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of consumers/parents who are satisfied with the services received. Numerator = number of positive responses. Denominator = total number of interviews conducted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Interviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Representative Sample; Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The

		sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of consumer IPPs developed in accordance with State policies and procedures. Numerator = number of consumer IPPs developed in accordance with State policies and procedures. Denominator = total number of consumer IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of

		consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of consumer IPPs that were reviewed or revised at required intervals (at least annually). Numerator = number of consumer IPPs that were reviewed or revised at required intervals. Denominator = total number of IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of consumer IPPs that were revised, when needed, to address changing needs. Numerator = number of consumer IPPs that were revised to address change in consumer needs. Denominator = number of consumer records reviewed that indicated a revision to the IPP was necessary to address changing needs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Representative Sample; Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants who received services, including the type, scope, amount, duration and frequency, specifically identified in the IPP. Numerator = number of consumers who received services that matched the services identified in the IPP. Denominator = total number of consumer IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of records that contain documentation the consumer was afforded the choice between waiver and institutional services. Numerator = number of consumer records that document consumer was afforded the choice between waiver and institutional services. Denominator = total number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☑ **Representative Sample** Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of IPPs that that are signed by the consumer/parent/legal representative indicating agreement with the services and providers identified in the IPP. Numerator = number of IPPs that are signed by the consumer/parent/legal representative. Denominator = total number of IPPs reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified**

		Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Individual issues identified during the State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews are documented in monitoring reports which are sent to the regional centers with the State's recommendations for resolution. Regional centers are responsible for developing and implementing plans for correction responsive to the State's recommendations. These plans are evaluated and approved by DHCS and DDS before the final monitoring report, containing the State's recommendations and corrective actions taken, are issued to the regional centers and forwarded to CMS.

Remediation plans for individual issues typically involve technical corrections to the IPP (e.g. obtaining a consumer signature or clarification of wording to reflect the agreed upon services that are being provided.) When indicated, a planning team meeting (at minimum includes the consumer and regional center representative) is held to discuss and obtain agreement on necessary modifications to the IPP.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

For those participants who receive respite, skilled nursing, transportation, and/or community-based training services identified as a need in their IPP, the opportunity to self-direct those services will be offered at the time of the IPP development. In support of personal control over the supports and services, the Waiver offers a voucher payment method for these services. The voucher is an option that enables adult consumers or family members to procure their own service. The family member is vendored by the regional center, and exercises decision making authority over services instead of services provided by staff hired by an authorized agency through the Regional Center.

Voucher services empower families, or the consumer, by giving them direct control over how and when the services are provided and will provide opportunities for closer scrutiny of the quality of those services.

For those selecting to self-direct the indicated services, FMS will be offered to provide assistance with selected administrative functions required in self-direction. Families/consumers will still have the freedom to directly control how and when the services are provided but won't have the burden of the services that FMS' provide, i.e., payroll, taxes, unemployment insurance, etc.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☐ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☑ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Participant direction opportunities are available to participants who live in their own private residence, the home of a family member, or in a community living arrangement as defined in Appendix C.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

During the IPP planning team meeting, the regional center case manager is responsible for informing the waiver participant of their choice of agency providers or to self-direct for respite, transportation, community-based training services and/or skilled nursing services. The case manager will provide prospective voucher recipients with information and requirements of this choice as required by Title 17, CCR §§54355 and 58886 (e.g. responsibilities and functions as either an employer of co-employer, requirements regarding the use of a financial management service, etc.) This information is provided so the participant can make an informed decision about choosing agency or self-directed method of service delivery.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

○ **The State does not provide for the direction of waiver services by a representative.**

◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☑ **Waiver services may be directed by a legal representative of the participant.**

☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Consumers (or their authorized, legal representative) have the opportunity to choose who may assist them in self-directing respite, transportation, community-based training service and/or skilled nursing services; however, the same requirements as specified in Title 17, CCR §§54355 and 58886 (e.g. responsibilities and functions as either an employer or co-employer, requirements regarding the use of a financial management service, etc.)apply. Further, all voucher recipients must be vendorized by the regional center in accordance with Title 17, CCR, §§ 54310 and 54326 (e.g. submission of required applicant identifying information, records maintenance requirements, etc.); and, regional centers will ensure that voucher recipients meet applicable laws ongoing and thereafter through oversight and monitoring activities.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Financial Management Service	☑	☐
Non-Medical Transportation	☑	☐
Community-Based Training Service	☑	☐
Respite Care	☑	☐
Skilled Nursing	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

- (●) **FMS are covered as the waiver service specified in Appendix C1/C3**

  The waiver service entitled:
  Financial Management Services
- ( ) **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The adult consumer or family member utilizing participant-directed services can act as a common law employer or a co-employer.

An FMS is an entity that functions as the adult consumer's agent or family member's agent in performing selected duties as follows:
o Fiscal Employer/Agent: An FE/A ensures that Federal, state and local employment taxes and labor and workers' compensation insurance rules related to household employment and payroll are implemented in an accurate and timely manner and that services are paid for appropriately and in a timely manner;
o Co-employer: When the individual is a co-employer, the FMS ensures that the necessary employer-related duties and tasks, including payroll, are carried out.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS providers are paid a flat rate set by the State.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assists participant in verifying support worker citizenship status**
- [x] **Collects and processes timesheets of support workers**
- [x] **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

  Specify:

  • Track, prepare and distribute reports (e.g., expenditure) to appropriate individual(s)/entities.
  • Maintain all source documentation related to the authorized service(s) and expenditures.
  • Maintain a separate accounting for each participant's participant-directed funds.

Supports furnished when the participant exercises budget authority:

- [ ] **Maintains a separate account for each participant's participant-directed budget**
- [ ] **Tracks and reports participant funds, disbursements and the balance of participant funds**
- [ ] **Processes and pays invoices for goods and services approved in the service plan**
- [ ] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

  Specify:

Additional functions/activities:

- ☐ **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☐ **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☐ **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

FMS providers are subject to periodic random audits by both regional centers and DDS. Additionally, specified providers pursuant to State law must obtain an independent audit or review or their financial statements annually. The results and accompanying management letters must be forwarded to the appropriate regional center. Subsequently, the regional center must require resolution of issues identified in the reports and notify DDS of all qualified opinion reports or reports noting significant issues that directly or indirectly impact regional center services. Further, a sample of claims at each regional center is reviewed as part of the biennial regional center audits conducted by DDS and reviewed by DHCS.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

- ☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

  Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

  As noted in appendix E-1(e), regional center case managers are responsible for informing the waiver participant of their choice of agency providers or to self-direct for respite, transportation, community-based training service and/or skilled nursing services. The case manager will provide prospective voucher recipients with information and requirements of this choice as required by Title 17, CCR §§54355 and 58886 (e.g. responsibilities and functions as either an employer of co-employer, requirements regarding the use of a financial management service (FMS), etc.)
- ☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Homemaker	☐
Financial Management Service	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Vehicle Modifications and Adaptations	☐
Non-Medical Transportation	☐
Optometric/Optician Services	☐
Communication Aides	☐
Home Health Aide	☐
Speech, Hearing and Language Services	☐
Specialized Medical Equipment and Supplies	☐
Chore Services	☐
Community-Based Training Service	☐
Environmental Accessibility Adaptations	☐
Prescription Lenses and Frames	☐
Personal Emergency Response Systems (PERS)	☐
Specialized Therapeutic Services	☐
Dental Services	☐
Respite Care	☐
Community Living Arrangements	☐
Skilled Nursing	☐
Nutritional Consultation	☐
Day Service	☐
Supported Employment (Enhanced Habilitation)	☐
Prevocational Services	☐
Psychology Services	☐
Transition/Set Up Expenses	☐
Behavioral Intervention Services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants are able to switch to non-participant directed services at any time. A planning team meeting is held to update the IPP, and the case manager facilitates the transition and assures no break in service.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The state does not involuntary terminate participant direction.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	16024	
Year 2	16346	
Year 3	16674	
Year 4	17009	
Year 5	17350	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

FMS Co-Employer entities function as legal employers in collaboration with family members or adult consumers, acting Co-Employers. The FMS Co-Employer must possess the ability to collect and process employee time records, assist family members or adult consumers, acting Co-Employers, in verifying the worker's eligibility for employment, process payroll, withholding, filing and payment of applicable federal, state and local employment related taxes and insurance, prepare and distribute monthly expenditure reports to the Co-Employer and the regional center; maintain all source documentation related to the authorized service(s) and expenditures, maintain separate accounting of funds used for each adult consumer or family member, and ensure payments do not exceed the amounts and rates authorized.

FMS Fiscal Employer/Agent (F/EA) entities function in collaboration with adult consumers or family members who choose to maintain their status as common law employers. For the purposes of processing payroll, the FMS F/EA must have the ability to process the worker pay, withholdings, filings and any required payments of applicable federal, state and local employment related taxes and insurance, and apply for and obtain authorization under Section 3504 of the Internal Revenue Code to be an agent for each consumer or family member represented. The FMS F/EA must be able to assist with the verification worker eligibility, collect and process employee time records, maintain all source documentation related to the authorized service(s) and expenditures, maintain separate accounting of funds used for each adult consumer or family member, and prepare and distribute monthly expenditure reports to the Employer and the regional center. The FMS may process reimbursements but must do so according to IRS regulations. The FMS F/EA must be able to ensure payments do not exceed the amounts and rates authorized.

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☑ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

- [ ] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

As required by the State Medicaid Manual (SMM) §2900.1, DD waiver recipients are afforded the right to a fair hearing if there is a disagreement with any actions taken by the regional center including the following; denial of eligibility, termination or reduction in services, denial of choice of services, denial of chosen provider, or disagreement with the amount of service. Pursuant to 42 CFR 431.206 and SMM §2900.2, information (in 12 different languages) regarding the fair hearing process, including related forms and a brochure describing the process, are available at http://www.dds.ca.gov/complaints/complt_fh.cfm. Additionally, this information is provided to every recipient in a notice whenever any of the events described previously occur.

If a recipient requests a fair hearing, a number of options are available to resolve the disagreement. The recipient may request an informal meeting with the regional center, or mediation. Consistent with SMM §2902.1, these steps are optional and do not take the place of the State level fair hearing. The recipient may choose to go straight to the fair hearing or may choose to try resolution at either an informal meeting or mediation. Even if the recipient initially chooses one of these two options, they may at anytime choose to proceed to the fair hearing.

As required by 42 CFR 431.230, if a recipient requests a fair hearing, services will not be terminated or reduced until a decision is rendered. Fair hearings are conducted by independent hearing officers with the State's Office of Administrative Hearings (OAH.) By State statute, and consistent with SMM §2903.5, the Director of DHCS, the State Medicaid Agency, has delegated his authority to adopt final decisions to the Director of OAH.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

DDS

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Pursuant to the California Welfare and Institutions Code, § 4731, a participant may pursue a Consumer Complaint against a regional center or service provider. The Consumer Complaint Process is the procedure to use if you believe that the regional center or a provider has violated or improperly withheld a right to which you are entitled under the law. Under this process, you are asking that the regional center or provider change its procedures for dealing with you and others in the future.

The initial referral of the complaint shall be to the Executive Director of the regional center. Upon receipt of the complaint, the Executive Director has 20 working days to investigate the matter and send a written proposed resolution to the participant or representative. If the participant or representative is not satisfied with the proposed resolution, the participant or representative shall refer the matter in writing to the Director of the DDS within 15 working days of receipt of the proposed resolution. The Director shall, within 45 days of receiving the complaint, issue a written administrative decision, and send a copy of the decision to the participant and Executive Director of the regional center.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Incident reporting is just one component of the Statewide Risk Mitigation and Management System, designed to enhance consumers' health, safety and/or well-being and to implement preventive strategies and interventions to mitigate such risks. This system is a coordinated effort amongst numerous agencies, including regional centers, the State's independent risk management contractor, the State's Quality Management Executive Committee (QMEC--consisting of executive level personnel from both DHCS and DDS to review data and trends identified through the multiple discovery activities and sources described in this and other sections throughout this waiver), DDS, and various licensing and protective service agencies.

DDS has promulgated regulations that describe special incident reporting (SIRs) requirements and define the incident types that require a SIR, including:

• Reasonably suspected abuse/exploitation including physical, sexual, fiduciary, emotional/mental, or physical/chemical restraint.
• Reasonably suspected neglect including failure to provide medical care for physical and mental health needs, prevent malnutrition or dehydration, protect from health and safety hazards, assist in personal hygiene or the provision of food, clothing or shelter or exercise the degree of care that a reasonable person would exercise in the position of having the care and custody of an elder or a dependent adult.
• A serious injury/accident including lacerations requiring sutures or staples, puncture wounds requiring medical treatment beyond first aid, fractures; dislocations, bites that break the skin and require medical treatment beyond first aid, internal bleeding requiring medical treatment beyond first aid, any medication errors, medication reactions that require medical treatment beyond first aid, or burns that require medical treatment beyond first aid.
• Any unplanned or unscheduled hospitalization due to the following conditions: respiratory illness, including but not limited, to asthma, tuberculosis, and chronic obstructive pulmonary disease; seizure-related; cardiac-related, including but not limited to, congestive heart failure, hypertension, and angina; internal infections, including but not limited to, ear, nose and throat, GI, kidney, dental, pelvic, or urinary tract; diabetes, including diabetes-related complications; wound/skin care, including but not limited to, cellulitis and decubutus; nutritional deficiencies, including but not limited to, anemia and dehydration; or involuntary psychiatric admission; unplanned hospitalizations.
• Deaths, regardless of cause.
• The consumer is a victim of a crime including the following: robbery, including theft using a firearm, knife, or cutting instrument or other dangerous weapons or methods which force or threaten a victim; aggravated assault, including a physical attack on a victim using hands, fist, feet or a firearm, knife or cutting instrument or other dangerous weapon; larceny, including the unlawful taking, carrying, leading, or riding away of property, except for motor vehicles, from the possession or constructive possession of another person; burglary, including forcible entry; unlawful non-forcible entry; and, attempted forcible entry of a structure to commit a felony or theft therein; or rape, including rape and attempts to commit rape.

Qualified providers that furnish services to all regional center consumers, regardless if the consumer is on the waiver, are required to report a SIR to the regional center within 24 hours after learning of the incident occurrence. The initial report may be by telephone; however, a written report with specified information (as outlined in Title 17 § 54327) must be submitted to the regional center within 48 hours of learning of the incident occurrence.

Regional centers, in turn, are mandated by Title 17, §54327.1 to submit SIRs (via the State's electronic SIR system) to DDS within two working days following initial receipt of the incident report or within two working days of learning of the incident.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DDS has overall state-level responsibility for planning, coordinating and overseeing implementation of the State's risk mitigation and management system for persons with developmental disabilities, of which training and education is a component.

Both DDS and the State's independent risk management contractor provide regional centers and/or qualified providers training and technical assistance on the legal obligations in abuse reporting; SIR documentation requirements; the definition of 'special incident'; best practices for identifying consumer abuse; using and maintaining the automated SIR system; risk assessment; and proactive risk assessment and prevention planning through the individualized program planning process. This training and education to regional center staff and providers enables these entities to adequately disseminate training and education materials to consumers/families on

abuse, risk assessment and mitigation.

Further, regional centers, pursuant to Title 17 §54327.2, must have a risk management and mitigation plan that addresses training for various parties mentioned above that is monitored by an internal risk management, assessment and planning committee.

The State's independent risk management contractor develops and disseminates training materials, newsletters, and a website (DDS Safety Net) on various subjects in consumer-friendly format relative to staying safe, keeping healthy, etc. In addition, regional centers are provided quarterly analysis and trends on their SIR data by the independent risk management contractor, allowing regional centers to develop and implement focused strategies to mitigate emerging trends in the SIR data.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Regional centers receive the initial SIR from appropriate entities and in turn report the SIR to DDS. As appropriate, licensing and/or protective services entities are notified by the regional center. The timelines for initial SIR reporting are outlined in G-1-b.

SIR Evaluation, Examination and Follow-up
Regional centers have local-level responsibility for evaluation, examination and follow-up of SIRs. Regional centers are required to report special incidents and follow-up activities to DDS via the electronic SIR system. Regional centers are required to pursue follow-up activities until there is a satisfactory resolution of the immediate issue and mitigation of future risk to participants. Upon receipt of the special incident report, the regional center:

1. Reviews the incident report, ensures participant's safety and contacts the participant's authorized representative, as appropriate.
2. Reports the incident to investigative/protective services agencies, as appropriate.
3. Enters the initial information into special incident reporting system within two working days of learning of the incident.
4. Engages in activities to protect the participant's health and welfare and to prevent future incidents.
5. Records medical and other health related care received by the participant for his/her significant medical conditions in the period prior to the special incident.
6. Reviews medical records and coroner reports to ensure appropriate medical attention was sought and/or given.
7. Coordinates with other agencies (e.g., licensing, protective services, law enforcement agencies, coroners, long-term care ombudsman, etc.) to gather and review the results of their investigations and using this information to prevent the recurrence of similar problems.
8. Conducts on-site and chart review activities to gather and report initial and follow-up SIR information.
9. Adds required information to the initial SIR within 30 working days following initial report and updates SIR on a flow basis.
10. Closes the SIR when all required information and all follow-up activities are completed and entered into the electronic reporting system.

DDS Report Review and Evaluation Process
DDS has state-level responsibility for evaluation and follow-up of SIR reports; DDS evaluates and follows up on special incidents by:

1. Daily review of SIR transmissions to ensure regulatory compliance and proper notifications have been made to legally required entities, and that appropriate follow-up activities are occurring. Immediate follow-up with regional centers is conducted, as needed, to ensure consumer health and safety has been assured.
2. Aggregating and analyzing SIR data by certain characteristics (i.e., regional centers, providers, incident types, residence and other relevant factors) on an ad-hoc basis.
3. Providing input to the State's independent risk management contractor for further analysis and to regional centers for follow-up as appropriate.

Regional centers are required to report additional information to DDS within 30 days of receiving the SIR, but this timeframe does not apply a requirement that the investigation must be completed by that time. The requirement is that the regional center must add information on a flow basis and close the SIR when all required information and all

follow up activities are completed and entered into the electronic reporting system. DDS has a well-established follow-up system to track "open" SIRs. The system includes regular contact with the regional center.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DDS has overall state-level responsibility for planning, coordinating and overseeing the implementation of the State's Risk Mitigation and Management System for all individuals with developmental disabilities, including those that are Waiver participants. DDS carries out this responsibility on an ongoing basis by:

1. Developing, implementing and maintaining a uniform, statewide automated SIR database system.
2. Reviewing individual SIRs daily to identify issues or concerns requiring additional follow-up.
3. Revising regulations, as needed, related to SIR requirements to address system requirements.
4. Providing SIR data (such as risk indicators, client characteristics, corrective actions, etc.) to the State's independent risk management contractor for further analyses and to regional centers for follow-up, as appropriate.
5. Providing training and technical assistance to regional centers on legal obligations in abuse reporting; documentation requirements; the definition of "special incident;" best practices for identifying consumer abuse; using and maintaining the automated SIR system; risk assessment; and proactive risk assessment and prevention planning through the individualized program planning process.
6. Developing and maintaining a statewide mortality review system that includes development and maintenance of a statewide database of all persons who have died, and conducting studies to educate and inform the service system so as to improve quality of life outcomes for participants.
7. Preparing, implementing and managing the risk assessment and mitigation contract.
8. Reviewing on-site highly unusual, suspicious and/or very sensitive individual incidents where DDS Headquarters involvement is indicated.

DHCS is the single state agency for the DD Waiver. DDS is the operating agency for the DD Waiver. DHCS and DDS exercise oversight of the waiver through the Biennial Collaborative On-Site HCBS Waiver Monitoring reviews at the 21 regional centers. Several components of the review address risk management activities, including SIRs.

1. DHCS and DDS review compliance with reporting, meeting mandated timelines and appropriate and complete follow-up activity through the review of DD Waiver participant records at the regional center and at day and living service providers for the review sample.
2. Additionally, DHCS and DDS review compliance with reporting, meeting mandated timelines and appropriate and complete follow-up activity for 10 SIRs for DD Waiver participants who are not in the sample.

DHCS performs additional focused on site reviews of SIRs when it is deemed necessary.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

◉ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

Restraints

California prohibits using restraint(s) on any person with a developmental disability, pursuant to CCR, Title 17 §50515 unless applicable licensing regulations regarding the use of bodily restraints are strictly adhered to and approved by the State's licensing entity, DSS CCL. Pursuant to Ca. Health and Safety Code § 1180.4(b), Group homes and Community Care Facilities may use seclusion or behavioral restraints for behavioral emergencies only when a person's behavior presents an imminent danger of serious harm to self or others. The facility must notify DSS CCL.

Seclusion

California prohibits placing any person with a developmental disability in seclusion, pursuant to CCR, Title 17 §§50515 and 56089. Pursuant to California Health and Safety Code § 1180.4(b), Group homes and Community Care Facilities may use seclusion or behavioral restraints for behavioral emergencies only when a person's behavior presents an imminent danger of serious harm to self or others. The facility must notify DSS CCL.

Oversight Responsibility

DSS CCL must authorize the use of bodily restraints.

A special incident report would be filed with the regional center and appropriate licensing/law enforcement agencies which would investigate and take action. DDS would be notified of any outcomes pursuant to the special incident reporting process.

○ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The unauthorized use of restrictive interventions is monitored in the DD Waiver through:
• Quarterly monitoring visits conducted by the regional center case manager and the ongoing contact with the participant by the case worker.
• Annual or unannounced visits by DSS CCL.

In California, the discovery of the unauthorized use of restraints and seclusion would result in the cancellation of the contract of the responsible provider. A special incident report would be filed with the regional center and licensing/law enforcement agencies (if applicable) which would investigate and take action. DDS would be notified of any outcomes pursuant to the special incident reporting process.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

For consumers who reside in community living arrangements where the provider has round-the-clock responsibility in residences that are not the participant's own home or home of a family member, the following entities have responsibility for monitoring those living arrangements:

• The consumer's prescribing physician (ongoing)
• Person-centered planning team through their monitoring of the IPP (as needed, and annually at a minimum.)
• Regional centers' monitoring of provider compliance with assisting the consumer in receiving medical care and medication management follow-up pursuant to the IPP (as needed, and quarterly at a minimum.)

Further, the State's mandated statewide competency-based training for direct support professionals employed in regional center vendored community care facilities has modules on medication management, including training on appropriate handling/dispensing of medications.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The State monitors medication management through the activities detailed in appendix H, which include (but are not limited to), the State's overall risk mitigation and management system and the Biennial Collaborative on-site HCBS Waiver Monitoring Review. The State's risk management contractor reviews electronic special incident report data for trends in medication errors and unplanned hospitalizations due to medication errors. As part of its contract with DDS, the risk management contractor also performs polypharmacy reviews and follow-up. Technical assistance and/or tools are developed on an as needed basis in response to SIR trends to prevent the occurrence of incidents. Further, in the state mandated DSP training (for all direct support professionals employed in regional center vendored community care facilities), there is a component on medication management.

Additionally, if the provider is licensed by the Department of Social Services (DSS), a review of medication policies/procedures is conducted. DSS and regional centers monitor ongoing thereafter through oversight and monitoring activities to address any issues relative to medication management.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

For applicable providers, all of the State's licensing and certification comprehensive requirements (CCR, Title 22) are in effect, including, but not limited to §§80075 and/or 87575.

Additionally, the State's mandated statewide competency-based training for direct support professionals employed in regional center vendored community care facilities has modules on medication management, including training on appropriate handling/dispensing of medications.

iii. Medication Error Reporting. *Select one of the following:*

- ◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  Pursuant to state regulations, all medication errors for participants who are under a provider's care are required to be reported to (1) the regional center and (2) the appropriate licensing entity.

  Regional centers, in turn, are required to notify DDS of medication errors.

  (b) Specify the types of medication errors that providers are required to *record:*

  Medication errors that occur when a participant is under a provider's care, including those where the provider is assisting the participant to self-administer.

  (c) Specify the types of medication errors that providers must *report* to the State:

  Medication errors that occur when a participant is under a provider's care, including those where the provider is assisting the participant to self-administer.
- ○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Please see Appendix G-3-i.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of special incidents reported within required timeframes.
Numerator = number of special incidents reported within required timeframes;
denominator = number of special incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Special incident report (SIR) database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Regional centers	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: Daily	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☑ **Other** Specify: In addition to reviewing any special incidents for consumers included in the random sample, a supplemental sample is

		reviewed of ten consumers with a reported special incident at each regional center.
	☑ **Other** Specify: On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: regional centers, independent risk management contractor	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of special incidents for which appropriate actions were taken. Numerator = number of special incidents for which appropriate actions were taken; denominator = number of special incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Special incident report (SIR) database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

		☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Regional centers	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Daily	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Representative Sample; Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential

		settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☑ **Other** Specify: In addition to reviewing any special incidents for consumers included in the random sample, a supplemental sample is reviewed of ten consumers with a reported special incident at each regional center.
	☑ **Other** Specify: On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: regional centers, independent risk management contractor	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of consumers whose special health care requirements or safety needs are met. Numerator = number of consumers whose special health care requirements or safety needs are met; denominator = total number of consumers reviewed with special health care requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Representative Sample; Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify:	

	On-site reviews are conducted at each regional center (RC) every two years. Focused follow-up reviews are conducted annually or more frequently as needed.

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of providers that maintain a safe environment and safeguard medications. Numerator = number of providers that maintain a safe environment and safeguard medications; denominator = total number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Site reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Representative Sample;

		Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☐ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: The sample is stratified based on three residential settings. The sample size at each RC is in direct proportion to the number of consumers in each setting at each RC.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Regional centers have the primary responsibility for ensuring appropriate steps are taken in response to special incidents. These steps may include; identifying the factors that led to the incident, ensuring service providers responded appropriately, assessing the need for provider training and determining if modifications to the consumer's IPP are needed. The actions taken are documented in the incident report or consumer record.

Daily, DDS staff review submitted special incident and, when necessary, follow-up with the regional center

Individual issues identified during the State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews are documented in monitoring reports which are sent to the regional centers with the State's recommendations for resolution. Regional centers are responsible for developing and implementing plans for correction responsive to the State's recommendations. These plans are evaluated and approved by DHCS and DDS before the final monitoring report, containing the State's recommendations and corrective actions taken, are issued to the regional centers and forwarded to CMS.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Regional centers Independent risk management contractor	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

California has excellent systems and structures in place that provide information and/or guide the quality improvement strategy (QIS). These include the risk management and mitigation system, regional center performance contracts, the Biennial Collaborative on-site HCBS Waiver Monitoring Reviews, biennial regional center fiscal audits, and the direct support professional (DSP) training program. All of these components are based on the quality model that starts with establishing clear expectations for performance (design), collecting data to determine if the expectations are met (discovery), taking steps to correct deficiencies (remediation), and utilizing information obtained to implement improvements and continuously monitor the system to determine if desired results were achieved (improvement).

While all the various aspects of the QIS have built-in continuous quality monitoring, trend identification, remediation and improvement responsibilities, it is important to get a coordinated, comprehensive look at the performance of all aspects of the service delivery system. To that end, the state has established the Quality Management Executive Committee (QMEC) consisting of executive level personnel from both DHCS and DDS. The involvement of DHCS in the QMEC ensures that the State Medicaid agency is actively involved in the assessment of waiver performance. One of the main functions of the QMEC is to analyze data and trends identified through the multiple discovery activities and sources described in this and other sections throughout this application. This analysis enables the QMEC to assess the efficacy of the system's design, discovery, remediation, and improvement activities. As a result of this analysis, the QMEC is able to prioritize suggested policy changes or system enhancements that may be necessary in response to identified trends.

As an example, the following is a more detailed description of the process employed by the QMEC in trend identification and coordination of system enhancement activities utilizing information from one component of the QIS. Although the design, discovery, remediation and improvement activities vary for each of the QIS components, the process described below is representative of the QMEC's role in identifying the need for and coordinating system improvements.

The State puts a premium on protecting consumers' health and welfare. This is evidenced by the commitment to establishing and overseeing a multi-faceted risk management and mitigation system. As a key component in this system, the State engages the services of an independent, specialized risk management and mitigation contractor possessing a multidisciplinary (clinical, research, data analysis, training, business) capacity. One of the responsibilities of this contractor is to analyze information from the State's electronic special incident reporting system. The QMEC uses the contractor's statistical analysis of incident report data and other related data sets to help determine statewide priorities and direct risk management activities. Remediation and system improvement activities directed by the QMEC include targeted technical assistance for regional centers experiencing an increase in incidents; working with a group of regional center risk management personnel in a effort to gather better actionable data; technical support in the development of remediation plans; modification of the State's required direct support professionals training for individuals employed in community care facilities; and development of mortality review guidelines and medical diagnosis checklists for common chronic conditions.

When the need for potential system enhancements is identified by the QMEC, the process often involves changes to existing regulation, statute and/or budgetary authority. Each of these steps requires that public input is sought before any changes are made. For example, the rules for promulgation of new regulations require the solicitation of public comments on the proposed regulations. Additionally, numerous legislative hearings are conducted during the development of the State's annual budget. Public testimony, both oral and written, is taken at these hearings which are historically widely attended and participated in by stakeholders (e.g. consumers, families and service providers) when issues concerning the service system for people with developmental disabilities are discussed. In the last several years, DDS has also convened workgroups to obtain input from stakeholders in developing proposals for system changes.

Stakeholder participation in this process is also accomplished through the Consumer Advisory Committee

(CAC). This standing committee consists of individuals who are members of and have been nominated by a local People First or self-advocacy group. The purpose of the CAC is to advise DDS on issues involving policies, programs, legislation, and regulations affecting the delivery of services and supports to people with developmental disabilities in California. In addition, DDS discusses issues, including new or potential policy changes with the CAC and ensures that appropriate DDS representatives attend CAC meetings based on the topics that are to be discussed.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of Monitoring and Analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The QIS is designed to incorporate continuous quality monitoring of all HCBS Waiver assurances. This enables the State to utilize data from the various discovery activities for the purpose of performing on-going assessments of the QIS, including the effectiveness of any system enhancements. As described in the previous section, the Quality Management Executive Committee (QMEC) has the primary role in making a coordinated system assessment. This includes assessing the effectiveness of system enhancements and the design of new discovery activities if needed. It is important to note that the multiple QIS discovery activities include input from and on-going communication with stakeholders, including consumers/families, service providers, regional center staff and State representatives. How system assessments are communicated with stakeholders is described below:

Regional Center Performance Contracts – Performance contracts measure progress on public policy and compliance measures for each regional center. These contracts are developed through a public process that includes input on performance objectives. Examples of these measures include the number of minors residing with families; the number of adults residing with their families, in independent or supported living, or Family Home Agency homes; compliance with DDS and independent fiscal audits; and compliance with individual program plan development requirements. The data for the measures in each contract is provided to regional centers every six months, including a year-end final report that is available to the public.

Independent Risk Management Contractor Activities – The risk management contractor produces and distributes a number of reports that are used to assess system improvement activities. These include: quarterly reports of increased incident occurrences and subsequent regional center responses to these increases; semi-annual reports of statewide incident trends which are posted on the DDS website; and an annual report to the legislature on statewide incident trends and remediation activities. Further, the risk management contractor participates, along with DDS representatives, in quarterly meetings with regional center risk management personnel as well as the training subcommittee of the regional centers Chief Counselor's committee (see below). These regular meetings provide a forum for reviewing the efficacy of systems improvements.

Regional Center Committees – DDS meets regularly with groups of regional center representatives who are organized in a number of topic and/or function specific standing committees. These committees include the regional center Chief Counselors (case management executives), risk management representatives, and

HCBS Waiver personnel (i.e. qualified mental retardation professionals). Participation in these committees affords DDS and regional center stakeholders regular opportunities to review and communicate about system performance and HCBS Waiver related policies. DDS' regular participation in these committees is a mechanism through which TA is provided, implementation and compliance issues discussed, and communication regarding system issues and performance occurs.

Regional Center Boards of Directors – As private, non-profit entities, each regional center is governed by a board of directors. The composition of these boards requires the inclusion of persons with developmental disabilities or family members/legal guardians. Additionally, each board must have an advisory committee comprised of a wide variety of providers of regional center services. These boards conduct regular public meetings and are tasked with the oversight of all regional center activities. This includes the review and implementation to the previously discussed regional center performance contracts. The composition requirements of the boards, in addition to the public nature of their activities, ensure that stakeholders have the opportunity to provide input on and receive information regarding regional center policies and system changes.

Consumer Advisory Committee (CAC) – The CAC, described above, meets quarterly and collaborates with DDS. During these meetings, DDS discusses and disseminates information on topics raised by CAC members, including new or potential policy changes.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Management Executive Committee (QMEC) is able to continuously evaluate the design of the QIS strategy due to the on-going nature of the discovery, remediation and improvement activities described in this application. In addition, the State utilizes information from national advocacy and provider organizations, other states, and CMS to identify potential design changes that would strengthen the QIS.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDS performs fiscal audits of each regional every two years, and completes follow-up audits of each regional center in alternate years or more frequently as needed. Regional centers are also required to contract with independent auditors to conduct an annual audit. The DDS audit is designed to "wrap around" the required independent audit to ensure comprehensive financial accountability. DDS reviews each regional center's annual independent audit report and follows up with the regional center regarding corrective action for each management comment identified in the independent auditor's report. DDS and regional centers also conduct audits of service providers.

Additionally, specified providers pursuant to State law must obtain an independent audit or review or their financial statements annually. The results and accompanying management letters must be forwarded to the appropriate regional center. Subsequently, the regional center must require resolution of issues identified in the reports and notify DDS of all qualified opinion reports or reports noting significant issues that directly or indirectly impact regional center services.

DHCS maintains on-going oversight of the audit functions of this Waiver as follows:
1. DHCS Audits and Investigations (A&I) reviews DDS regional center Pre-Audit Review Package with contains: DDS' contracts and Contract Budget Summaries; summary of regional center budget; summary of state claims; summary of advances and offsets; independent audit reports and management letters; regional center response to management letters; and DDS review of independent audit work papers.
2. DHCS A&I reviews DDS draft regional center audit reports and notifies DDS if material findings are noted.
3. DHCS A&I participates in vendor audit entrance/exit conferences as appropriate.
4. DHCS A&I reviews draft DDS vendor audit reports and audit working papers.
5. DHCS submits annual report of DHCS A&I's oversight activities to CMS.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of claims paid in accordance with the reimbursement methodology in the approved waiver. Numerator = number of claims paid in accordance with the reimbursement methodology in the approved waiver; denominator = total number of claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS Biennial Regional Center audits

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 5-10% of the most heavily

		utilized services are sampled to verify accuracy of billing. Lesser utilized services are also sampled for review at a rate of less than 5%.
	☑ **Other** Specify: Fiscal audits are conducted at each regional center every two years. Follow-up fiscal audits are conducted annually or more frequently as needed.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDS audits of regional center vendors

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: DDS fiscal vendor audits are conducted based on a random sample of vendors with annual expenditures

		over $100,000 or upon referral.
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Vendor audits conducted by regional centers

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Regional centers	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Each regional center must conduct a fiscal audit no less than 4% of the total number of vendors in specified service categories for which payments in the prior year totaled $100,000 or less.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of claims paid in accordance with the consumer's authorized services. Numerator = number of claims paid in accordance with the consumer's authorized services; denominator = total number of claims for participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Representative Sample; Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☑ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group:

N/A		Based on 1) community care facility 2) independent or supported living 3)residing with family. Sample size at each RC is in direct proportion to the number of consumers in each residence type in each RC
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center every two years. Focused follow-up reviews are conducted annually or more frequently as needed.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of consumers who were enrolled on the waiver prior to the generation of claims for federal reimbursement. Numerator = number of consumers

who were enrolled on the waiver prior to the generation of claims for federal reimbursement; denominator = total number of consumer records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews conducted during State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Confidence Interval = 3.01 Based on sample size of 1050, population of 95000, and 95% confidence level
☑ **Other** Specify:	☑ **Annually**	☑ **Stratified** Describe Group: Based on 1) community care facility 2) independent or supported living 3)residing with family. Sample size at each RC is in direct proportion to the number of consumers in each residence type in each RC
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: On-site reviews are conducted at each regional center every two years. Focused	

follow-up reviews are conducted annually or more frequently as needed.

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
N/A

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Individual issues identified during any of the audit and oversight activities above require corrective actions to be developed by either the regional center or vendor. These corrective actions are evaluated and approved by DDS and included in the final audit reports. DHCS provides oversight of this process.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other**

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- **No**
- **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The rate methodologies for services provided in this waiver are as follows:

Behavior Intervention Service
This service is comprised of the following subcategories:

A. Non-Facility-Based Behavior Intervention Services– Providers in this subcategory are Behavior Analyst, Associate Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, Psychiatrist, Psychiatric Technician, Crisis Team, Client/Parent Support, Parent Support Services, Individual/Family Training Providers, Family Counselor, Behavior Intervention Training and Behavioral Technician. There are two rate setting methodologies for all providers in this subcategory (except psychiatrists – see below.) If the provider does not have a "usual and customary" rate as described below, then the rate is established using the median rate setting methodology.

1) The usual and customary rate methodology – Per California Code of Regulations (CCR), Title 17, Section 57210 (19), a usual and customary rate "means the rate which is regularly charged by a vendor for a service that is used by both regional center consumers and/or their families and where at least 30% of the recipients of the given service are not regional center consumers or their families. If more than one rate is charged for a given service, the rate determined to be the usual and customary rate for a regional center consumer and/or family shall not exceed whichever rate is regularly charged to members of the general public who are seeking the service for an individual with a developmental disability who is not a regional center consumer, and any difference between the two rates must be for extra services provided and not imposed as a surcharge to cover the cost of measures necessary for the vendor to achieve compliance with the Americans With Disabilities Act."
2) The median rate setting methodology – This methodology applies if the usual and customary rate methodology is not applicable to the provider. This methodology requires that rates negotiated with new providers may not exceed the regional center's current median rate for the same service, or the statewide current median rate, whichever is lower.
3) Schedule of Maximum Allowances - The rates for psychiatrists are determined by the "Schedule of Maximum Allowances (SMA)." State regulations define the SMA as the current rate established by the single-state Medicaid agency for services reimbursable under the Medi-Cal program. The SMA is the maximum amount that can be paid for the service. For providers who have a usual and customary rate that is less than the SMA, the regional center

shall pay the provider's usual and customary rate.
B. Crisis Support – The following two rate methodologies apply for these providers;
1) The usual and customary rate methodology – As defined previously or, if the provider does not have a usual and customary rate;
2) The median rate setting methodology - As defined previously.

Community Living Arrangement Services
This service is comprised of the following subcategories:

A. Licensed/Certified Residential Services – Providers in this subcategory are Foster Family Agency/Certified Family Home, Foster Family Home, Small Family Home, Group Home, Adult Residential Facility, Residential Facility for the Elderly, Out of State Residential Facility, Adult Residential Facility for Persons with Special Health Care Needs and Family Home Agency.
There are two rate setting methodologies for all providers in this subcategory (except Out of State Residential Facility – see below.)

1) Alternative Residential Model (ARM) methodology – This is the most typical methodology used in setting rates for the licensed/certified providers vendored to provide residential services. Within this methodology, 14 different rate/service levels were established using a cost-based study of providers using actual costs. Individual providers apply to be vendored at one of these rate/service levels based upon the staffing ratios, service design, personnel qualifications and use of consultant services described in their program design. The allowable costs used to calculate ARM rates include the following cost components: wages and benefits for direct supervision (those activities in which direct care staff provide care, supervision, training and support to promote the consumer's functioning) personnel, consultant services, general administrative costs (ex staff training, licenses), housing, furniture, insurance, utilities, food, housekeeping supplies and laundry services, personal care items, transportation, and wages and benefits (for management and staff providing cooking, house cleaning, maintenance). Note: This is not the rate that is claimed for FFP. See Appendix I-5 for a description of the method used to isolate and exclude room and board costs from the rate for purposes of Medicaid payment.

2) The median rate setting methodology – This methodology, as defined previously, is applicable for licensed/certified settings when the program service design (e.g., personnel qualifications, mandated staff ratios, programming, use of consultants) is not addressed within the ARM rate setting structure detailed above, and;
3) Out-of-state rate methodology – This methodology is applicable for out-of-state residential providers. The rate paid is the established rate for that service, paid by that State in the provision of that service to their own service population of individuals with developmental disabilities.
B. Supported Living Services provided in a consumer's own home (non-licensed/certified) – Supported Living Services providers are in this subcategory. Maximum rates for these providers are determined using the median rate methodology, as defined previously.

Day Services
This service is comprised of the following subcategories:

A. Community-Based Day Services – There are two rate setting methodologies for providers in this subcategory.
1) Rates set pursuant to a cost statement methodology – This methodology is used to determine the applicable daily rate for Activity Center, Adult Development Center and Behavior Management Program providers. This methodology is also used to determine the applicable hourly rate for Independent Living Program and Social Recreation Program providers. Under this methodology, new vendors are assigned a "new vendor" rate, based on the type of service provided, until a permanent rate is established, within upper and lower limits, using actual cost information as described below.
Note: Effective 7/1/03, pursuant to State law, rates for new providers are set at the fixed, new vendor rate for each service.

a) For the providers identified above, the cost-based rates are calculated based on 12 consecutive months of allowable costs related to services to consumers and actual days or hours of consumer attendance. Only costs attributable to the provision of the specific service are included. The following allowable cost information is utilized in determining the rate:
• Total gross salary and wages for all employees (direct service and supervisory) attributable to the provision of the specific service.
• Fringe benefit costs associated with salary and wage costs.
• Operating expenses including furniture, staff recruitment, license or certification fees, association dues or fees.
• Management organization costs (costs for administrative support provided for the delivery of the specific service.)

The total of the allowable costs above is then divided by the vendor's actual hours or days of consumer attendance to determine the daily or hourly rate per consumer.

b) The calculation for the range of rates for each service category is described below.
• The mean of rates of all like service providers is determined by adding the rates calculated in a) above for all vendors and dividing the sum of these rates by the total number of providers.
• The mean is then multiplied by 50 percent to determine the range. This range is then compared to the range determined for like services in fiscal year 1991-1992 (base year), and adjusted for any COLA. The lower of these two ranges is then divided by two and used for further calculations. The upper limit is determined by adding the amount calculated in the step above to the mean. Conversely, the lower limit is determined by subtracting the amount calculated in the step above from the mean.
2) The median rate setting methodology – This methodology, as defined previously, is used to determine the applicable daily rate for In-Home Day Program, Creative Art Program, Community Integration Program and Community Activities Support Program providers. This methodology is also used to determine the applicable hourly rate for Adaptive Skills Trainer, Socialization Training Program, Personal Assistance and Independent Living Specialist providers.
B. Therapeutic/Activity-Based Day Services – The providers in this subcategory are Specialized Recreation Therapy, Special Olympics, Sports Club, Art Therapist, Dance Therapist, Music Therapist and Recreational Therapist. There are two rate setting methodologies for providers in this subcategory. If the provider does not have a "usual and customary" rate, then the maximum rate is established using the median rate setting methodology. Usual and customary and median rate are defined previously.
C. Mobility Related Day Services – The providers in this subcategory are Driver Trainer, Mobility Training Services Agency and Mobility Training Services Individual. There are two rate setting methodologies for providers in this subcategory. If the provider does not have a "usual and customary" rate, then the maximum rate is established using the median rate setting methodology. Usual and customary and median rate are defined previously.

Home Health Aide
The maximum rates for home health aides are based on the "Schedule of Maximum Allowances (SMA)", as defined previously.

Homemaker
There are two rate setting methodologies for homemakers. If the provider does not have a "usual and customary" rate, then the maximum rate is established using the median rate setting methodology. Usual and customary and median rate are defined previously.

Prevocational Services
Work Activity Program rates are set via cost statement. Prior to 7/1/06, newly vendored providers received the "new vendor" rate until a cost statement rate, not exceeding the maximum amount, was established as described below.
Note: Effective 7/1/06, pursuant to State law, rates for new Work Activity Program providers are set at the fixed, new vendor rate.

The costs used to calculate the daily rate are based on actual allowable costs in a historical period of at least three months ending no later than March 31 preceding the payment year for which the rate is being established. Only costs attributable to the provision of the work activity program service are included. The following information is used to calculate the rate:
• Staff salaries and wages (direct service and administrative)
• Fringe benefit costs (for staff identified above)
• Operating expenses
The total of the allowable costs is then divided by the days of actual consumer attendance to determine the rate per consumer. If the calculated rate exceeds the maximum allowable rate, the provider's rate shall be reduced to the maximum for the provider's size. (The maximum allowable rate is set as the mean plus one standard deviation for each size grouping of providers.)

Respite Care
There are two subcategories for this service.

A. In-Home Respite Care – There are two rate setting methodologies for providers in this subcategory.

CONTINUATION OF I-2(a) RATE DETERMINATION METHODS CAN BE FOUND UNDER I-2(b) FLOW OF BILLINGS

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

APPENDIX I-2(b) FLOW OF BILLINGS:
Claims for services provided are submitted to regional centers by providers, referred to as regional center vendors. These claims are subsequently submitted to DDS, the Organized Health Care Delivery System (OHCDS) for this Waiver. Under an interagency agreement with DHCS, DDS prepares and submits invoices to DHCS for valid, reimbursable costs (see item I-2-d.)
The Regional Centers then bill DDS, which operates the Waiver program under an interagency agreement and fiscal agent contract with the Department of Health Services, the Medicaid agency.

CONTINUATION OF I-2(a) RATE DETERMINATION METHODS:
1) Rates set in State regulation – This applies to individual respite providers and respite purchased through vouchers. Per Title 17, CCR, Section 57332(c)(3), the current rate for this service is $10.71 per hour.
2) Rates set pursuant to a cost statement (as defined previously under "Day Services.) – This methodology applies to In-Home Respite Service Agency providers.
B. Out-of-Home Respite Care – There are three rate setting methodologies for providers in this subcategory.
1) Rates based on the Alternative Residential Model (ARM defined previously under Community Living Arrangements) – This methodology applies to residential facilities with established ARM rates that also provide respite. Per Title 17, CCR, Section 57332(c)(6), the respite rate is 1/21 of the established monthly ARM rate.
2) The unusual and customary rate methodology – This methodology, as defined previously, applies to day care (adult and child) and camping services providers.
3) Median rate setting methodology – This methodology, as defined previously is applicable the providers listed in #2 above who do not have a usual and customary rate. In these instances, the maximum rate is established using the median rate setting methodology.

Supported Employment
Supported employment rates for all providers are set in State statute [Welfare and Institutions Code Section 4860(a)(1)] at $30.82 per job coach hour.

Speech, Hearing Language Services
The maximum rates for all providers of this service are based on the SMA, as defined previously.

Dental Services
The maximum rates for this service are based on the SMA, as defined previously.

Optometric/Optician Services
The maximum rates for this service are based on the SMA, as defined previously.

Prescription Lenses and Frames
The maximum rates for this service are based on the SMA, as defined previously.

Psychology Services
The maximum rates for this service are based on the SMA, as defined previously.

Chore Services
The rates for chore services providers are determined utilizing the usual and customary rate methodology, as previously defined.

Community-Based Training Service
The maximum rate for this service is set in State statute [Welfare and Institutions Code Section 4688.21(c)(7)] at $13.47 per hour.

Communication Aides
There are two rate setting methodologies for all communication aides providers. If the provider does not have a "usual and customary" rate (U&C), then the maximum rate is established using the median rate setting methodology. U&C and median rate are defined previously.

Environmental Accessibility Adaptations
The rates for contractors providing this service are determined utilizing the U&C rate methodology, as previously

defined.

Financial Management Services (FMS)
Rates for FMS are set in State regulation, Title 17, CCR, Section 58888(b). The rates range from $45 to $95 per month depending on the number of participant directed services used.

Non-Medical Transportation
There are three rate setting methodologies for this service:
1) The U&C rate methodology – This methodology, as defined previously, applies to transportation assistants and public transit authorities.
2) Median rate setting methodology – This methodology, as defined previously is used to establish the maximum rate for the following providers; transportation company, transportation-additional component and transportation broker.
3) Rate based on regional center employee travel reimbursement – The maximum rate paid to individual transportation providers is established as the travel rate paid by the regional center to its own employees.

Nutritional Consultation
The rates for nutritional consultation providers are determined utilizing the U&C rate methodology, as previously defined.

Personal Emergency Response Systems (PERS)
The rates for PERS providers are determined utilizing the U&C rate methodology, as previously defined.

Skilled Nursing
The maximum rates for this service are based on the SMA, as defined previously.

Specialized Medical Equipment and Supplies
The maximum rates for this service are based on the SMA, as defined previously.

Specialized Therapeutic Services
The maximum rates for these services are established utilizing the median rate setting methodology, as defined previously.

Transition/Set-Up Expenses
The rates for transition/set-up expenses are determined utilizing the U&C rate methodology, as previously defined.

Vehicle Modifications and Adaptations
The rates for vehicle modifications and adaptations are determined utilizing the U&C rate methodology, as previously defined.

Rate determination methodologies are set in State statute and/or by regulations The Legislature conducts hearings that are open to the public and allow for public comment prior to amending state law. Prior to finalization of any proposed regulation, interested stakeholders have the opportunity to provide comment on proposed regulations during the 45-day comment period. Stakeholders are notified of the proposed regulatory change in the following manner; by direct notification by the State agency, publication of the proposed change in regulation in the California Regulatory Notice Register, and publication on the agency's website.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- ○ **No. State or local government agencies do not certify expenditures for waiver services.**
- ◉ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☑ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

DDS, with DHCS oversight, certifies that the public expenditures for waiver services are based only on the total costs of services provided. By using the methods described in items I-2-d and I-3-a, DDS ensures that only those costs that 1) are provided to eligible individuals, and 2) are for services identified in the waiver, are included on invoices sent to DHCS to claim FFP. As detailed in item I-1, claims for waiver services are subjected to regular periodic audits and reviews by State, regional center and independent auditors.

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Claims are processed and validated at all levels through automated processes. Only claims for services for which a purchase authorization, based on decisions made in development of the individual service plan (IPP), is in place are able to be processed for provider payment by the regional center.

Regional centers transmit all expenditures (claims) to DDS through a system of main frame computers. At DDS the expenditures are processed though a specialized filter program to determine if:
1. The service recipient (consumer) was enrolled on the Waiver at the time of service.
2. The consumer was eligible for Medi-Cal at the time of service.
3. The service provided is eligible for FFP.
A claim for FFP is only completed if all three of the conditions above are met.

As described elsewhere in this application, the State's Biennial Collaborative on-site HCBS Waiver Monitoring Reviews also include verification that a statistically valid random sample of consumer IPPs identify all services purchased by regional centers. Further, each year all consumers are provided a complete listing of all the services funded (and paid for) on their behalf, pursuant to their IPP. This listing includes the service type, units, and month of service and the amount paid. The state law requiring the provision of an annual statement was implemented for the purpose of assuring that the services and supports paid for, were delivered to the recipient.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

  Payments to providers for authorized services are processed through the Uniform Fiscal System (UFS). The system establishes and tracks regional center authorization and billing data including vendor (provider) number, purchase authorization number, consumer identification and eligibility information, service code, service rate, claim amount, and claim date. Waiver services will not be paid unless the appropriate authorization and billing data are present. Regional centers transmit to DDS all service authorization and billing data necessary to support the provider claims to provide a complete audit trail. Regional centers vendors, regional centers and DDS are required to maintain documentation to support financial accountability in accordance with federal requirements. In addition to the controls contained in UFS to prevent possible erroneous payments, oversight of appropriate claiming also includes provider audits conducted by regional centers and DDS.

  Only claims determined valid by DDS through the process described in item I-2-d are submitted to DHCS for FFP and reporting as expenditures on the CMS-64.

- **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

DDS, as the operating agency and OHCDS for this Waiver, acts as the limited fiscal agent for all waiver services. In this role, through processes described previously, DDS verifies the appropriateness of claims submitted by regional centers and submits invoices to DHCS for FFP. The requirements for DDS in this role, as well as the financial accountability oversight responsibility of DHCS, are outlined in an interagency agreement between DHCS and DDS.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) Waiver services will be reimbursed through an Organized Health Care Delivery System (OHCDS) operated by DDS, which is the enrolled Medicaid provider for these services. DDS provides Medicaid services (outside the waiver) through its operation of state developmental centers. HCBS waiver and case management services are provided through, 21 private non-profit entities known as regional centers which are under contract with DDS to coordinate, counsel, advocate and arrange for individualized services and supports for people with developmental disabilities and their families.

(b)The DDS OHCDS is an open network. Regional centers evaluate and approve prospective providers through a process referred to as "vendorization." The purpose of vendorization is to ensure that the provider meets DDS and HCBS waiver qualifications and is enrolled in the regional center payment system. The regional centers do not have the ability to contract selectively or otherwise restrict the number of providers reimbursed for DDS services.

(c) Consumers select their providers through the development and implementation of an individual program plan ("IPP"). A consumer is not limited to providers already vendored by the regional center. If a consumer selects another provider, that provider is then vendored to ensure that it meets provider qualifications and is enrolled in the regional center's payment system.

(d) DDS establishes the qualifications for providers. The regional centers, as agents of DDS, are responsible for ensuring that providers meet all applicable qualifications. If they do, they are then vendored and included in the OHCDS.

(e) DDS is responsible for overseeing the operation of the OHCDS. This includes assuring that the regional centers review the qualifications of all providers (through the vendor process) and require providers to meet all applicable Medicaid requirements (e.g., the maintenance of necessary documentation).

(f) The regional centers pay enrolled providers based on the submission of claims. DDS then reimburses the regional centers for these expenditures, plus administrative expenses based on time studies. DDS certifies these expenditures to DHCS for reimbursement of the federal share. There is no "mark up" of expenditures. The amount that the DDS OHCDS bills for Waiver services equals the amount that it reimburses the regional centers plus its administrative costs.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☐ **Appropriation of State Tax Revenues to the State Medicaid agency**

☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

DDS directly incurs the full cost of waiver services. The non-federal share for these costs is appropriated directly to DDS through the State budget process. The source of all non-federal, or matching, funds used in computing the waiver costs is from State revenues. Therefore, no federal funds are used to match other federal funds.

As described in item I-2-c, the total amount paid for waiver services is submitted to DHCS by DDS via certified public expenditures as the basis for claiming of FFP.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid

Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

All claims for Habilitation-Community Living Arrangement Services (CLAS) provided in residential settings other than the consumer's personal home are validated in the waiver billing system to ensure the cost of room and board is excluded from the claim prior to claiming FFP. In California, the cost of room and board is equivalent to the Supplemental Security Income/State Supplement Payment (SSI/SSP) amount. Rates for providers of CLAS include the amount for room and board and, if necessary, an additional amount for the provision of support services. Prior to claiming FFP, the amount of the claim is compared to the provider's rate to ensure that only the amount in excess of the SSI/SSP amount is claimed for FFP. For example, if a provider's rate is $2,000/month, and the SSI/SSP amount equals $960, the Waiver billing system will not process claims that are more than $1,040 ($2,000 - $960 = $1,040).

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	25383.13	14663.00	40046.13	55058.00	11871.00	66929.00	26882.87
2	25383.77	14957.00	40340.77	51306.00	12109.00	63415.00	23074.23
3	25384.35	15257.00	40641.35	50287.00	12353.00	62640.00	21998.65
4	25384.87	15564.00	40948.87	49294.00	12601.00	61895.00	20946.13
5	25385.35	15876.00	41261.35	48551.00	12854.00	61405.00	20143.65

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR
Year 1	100000	100000
Year 2	105000	105000
Year 3	110000	110000
Year 4	115000	115000
Year 5	120000	120000

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) is calculated by dividing the total number of enrolled days of all waiver participants by the unduplicated recipients reported in the CMS 372 for waiver year 27 (2008/09)

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The Factor D utilization factors for waiver services are derived from actual expenditures and unduplicated users for State fiscal year 2010-11 (July 1, 2010 to June 30, 2011) for services provided to persons enrolled on the Home and Community-based Services Waiver for the Developmentally Disabled (HCBS DD Waiver.) The per capita cost, by service, was trended forward to reflect increases in the number of persons who will be served during the renewal period. Utilization adjustments take into account the ALOS calculation above.
The number of eligible recipients was estimated by starting in year one with 100,000, an increase of 5.2% over the estimated eligible participants at September 30, 2011, and increasing caseload to 105,000 in year 2, 110,000 in year 3, 115,000 in year 4, and 120,000 in year 5. Estimates of eligible recipients by service for each proposed year of the Waiver were based on the ratio of actual recipients of service to the total for State fiscal year 2010-11.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' equals the average per capita annual costs for all other Medicaid services (ancillary) to HCBS DD Waiver recipients (excluding HCBS DD Waiver costs). These estimates are based on actual costs from the CMS 372 for waiver year 27 (2008-09) projected out with a growth factor over the duration of the waiver renewal based on the California Consumer Price Index.

The following are assumptions used in deriving the Factor D':
• The cost of all State Plan services furnished in addition to HCBS DD Waiver services while the participant was on the HCBS DD Waiver, including, but not limited to:
o State Plan home health services;
o State Plan personal care services authorized through the county's In Home Supportive Services program;
o Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services;
o Adult day health care;
o Short-term institutionalization (hospitalization or Nursing Facility) which began after the participant's first day of waiver services and ended before the end of the waiver year, if the person returned to the waiver.
o Medical equipment and supplies covered under the State Plan;
o Non-emergency transportation services covered under the State Plan; and
o Outpatient clinic and physician services covered under the State Plan.

• Factor D' does not include the following:
o The costs of institutional care, if the person did NOT return to the HCBS DD Waiver following institutionalization;
o Institutional costs incurred BEFORE the person is first served under the HCBS DD Waiver in the specified waiver year;
o Costs for institutional respite care provided as a service under the HCBS DD Waiver. Such costs are included in the calculation of costs under Factor D; or
o Medicare Part D drug costs are not included in the Factor D' estimates.

The Factor D' is projected to increase 0.75% for 2009/10, 1.73% for 2010-11, 2.22% for 2011/12, and 2.01% for 2012/13 and thereafter, in accordance with the current California Consumer Price Index and the approval of the State of California funding authorities.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G equals the estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the Waiver, were the Waiver not granted. Factor G estimates for inpatient intermediate care facility subacute, and hospital LOC are derived from the 2009 weighted daily facility rate for the State of California's five developmental centers and one small facility and the rates for community based ICF/MR-DDs, ICF/MR-DD-Hs and ICF/MR-DD-Ns times 365 days a year.

The following assumption are used in deriving the Factor G:
• The Lanterman Developmental Center will cease operations and close by June 30, 2014.
• Factor G (inpatient costs) is projected to increase at 0.75% for 2009/10, 1.73% for 2010-11, 2.22% for

2011/12, and 2.01% for 2012/13 and thereafter, in accordance with the current California Consumer Price Index and the approval of the State of California funding authorities.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Factor G' estimates for State Plan services utilization for inpatient intermediate care facility, subacute and hospital level of care are derived from experience as reported in the CMS 372 report for waiver year 27 (2008-09) projected out with a growth factor over the horizon of the waiver based on the California Consumer Price Index.

Other assumptions used for obtaining the aggregate Factor G' waiver are described below.
• The cost of all State Plan services furnished during an inpatient stay.
• The Lanterman Developmental Center will cease operations and close by June 30, 2014.
• Factor G' is projected to increase is projected to increase at 0.75% for 2009/10, 1.73% for 2010-11, 2.22% for 2011/12, and 2.01% for 2012/13 and thereafter, in accordance with the current California Consumer Price Index and the approval of the State of California funding authorities.
• Medicare Part D drug costs are not included in the Factor G' estimates.

Other assumptions used for obtaining the aggregate Factor G' waiver are described below.
• The cost of all State Plan services furnished during an inpatient stay.
• The Lanterman Developmental Center will cease operations and close by June 30, 2014.
• Factor G' is projected to increase is projected to increase at 0.75% for 2009/10, 1.45% for 2010-11, 2.22% for 2011/12, and 2.01% for 2013/14 and thereafter, in accordance with the current California Consumer Price Index and the approval of the State of California funding authorities.
• Medicare Part D drug costs are not included in the Factor G' estimates.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Behavioral Intervention Services	
Community Living Arrangements	
Day Service	
Home Health Aide	
Homemaker	
Prevocational Services	
Respite Care	
Supported Employment (Enhanced Habilitation)	
Chore Services	
Communication Aides	
Community-Based Training Service	
Dental Services	
Environmental Accessibility Adaptations	
Financial Management Service	
Non-Medical Transportation	
Nutritional Consultation	
Optometric/Optician Services	
Personal Emergency Response Systems (PERS)	
Prescription Lenses and Frames	
Psychology Services	

Waiver Services	
Skilled Nursing	
Specialized Medical Equipment and Supplies	
Specialized Therapeutic Services	
Speech, Hearing and Language Services	
Transition/Set Up Expenses	
Vehicle Modifications and Adaptations	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Intervention Services Total:						**114259495.87**
Behavior Intervention Services	Hour	16428	164.20	40.72	**109841287.87**	
Crisis Support	Daily	92	60.03	800.00	**4418208.00**	
Community Living Arrangements Total:						**1221059888.14**
Licensed/Certified Residential Services	Month	29716	11.00	2596.94	**848877359.44**	
Supported Living Services	Hour	8972	1805.95	22.97	**372182528.70**	
Day Service Total:						**742046435.91**
Community-based Day Services	Daily	48291	200.04	61.76	**596609730.09**	
Therapeutic/Activity-based Day Services	Hour	298	85.79	40.45	**1034121.24**	
Community-based Day Services	Hour	16564	459.72	18.91	**143995907.33**	
Therapeutic/Activity-based Day Services	Month	409	11.00	50.00	**224950.00**	
Mobility-Related Day Services	Hour	213	23.66	36.06	**181727.25**	
Home Health Aide Total:						**17175436.99**
Home Health Aide	Hour	1856	489.63	18.90	**17175436.99**	
Homemaker Total:						**8100012.69**
Homemaker	Hour	990	489.93	16.70	**8100012.69**	

GRAND TOTAL:	**2538313490.87**
Total Estimated Unduplicated Participants:	**100000**
Factor D (Divide total by number of participants):	**25383.13**
Average Length of Stay on the Waiver:	11

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:						**44986420.15**
Prevocational Services	Daily	8103	157.32	35.29	**44986420.15**	
Respite Care Total:						**145045791.38**
In-Home Respite Care	Hour	34665	219.46	15.04	**114418016.74**	
Out-of-Home Respite Care	Daily	2360	46.27	71.11	**7765012.89**	
Family Support Respite Care	Hour	3350	718.39	9.50	**22862761.75**	
Supported Employment (Enhanced Habilitation) Total:						**37883046.52**
Supported Employment (Enhanced Habilitation)	Hour	4528	271.46	30.82	**37883046.52**	
Chore Services Total:						**40614.77**
Chore Services	Hour	8	240.04	21.15	**40614.77**	
Communication Aides Total:						**1027218.29**
Communication Aides	Hour	974	25.83	40.83	**1027218.29**	
Community-Based Training Service Total:						**13044348.00**
Community-Based Training Service	Hour	1614	600.00	13.47	**13044348.00**	
Dental Services Total:						**2939904.00**
Dental Services	Visit	5220	1.76	320.00	**2939904.00**	
Environmental Accessibility Adaptations Total:						**412250.00**
Environmental Accessibility Adaptations	Adaptation	97	1.00	4250.00	**412250.00**	
Financial Management Service Total:						**13484094.80**
Financial Management Service	Month	25327	11.00	48.40	**13484094.80**	
Non-Medical Transportation Total:						**164153533.95**
Individual Transportation Providers	Miles	4772	2807.99	0.55	**7369850.55**	
Transportation Companies	Daily	42312	173.08	20.47	**149909198.85**	
Public Transit/Rental/Taxi	Month	9961	11.00	62.74	**6874484.54**	
Nutritional Consultation Total:						**93266.25**
Nutritional Consultation	Hour	285	7.70	42.50	**93266.25**	
Optometric/Optician Services Total:						**17363.91**

GRAND TOTAL:	**2538313490.87**
Total Estimated Unduplicated Participants:	**100000**
Factor D (Divide total by number of participants):	**25383.13**
Average Length of Stay on the Waiver:	11

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Optometric/Optician Services	Visit	410	1.14	37.15	**17363.91**	
Personal Emergency Response Systems (PERS) Total:						**206744.89**
Personal Emergency Response Systems (PERS)	Month	589	11.00	31.91	**206744.89**	
Prescription Lenses and Frames Total:						**232778.61**
Prescription Lenses and Frames	Piece	2403	1.00	96.87	**232778.61**	
Psychology Services Total:						**766934.26**
Psychology Services	Hour	1486	12.35	41.79	**766934.26**	
Skilled Nursing Total:						**6861400.06**
Skilled Nursing	Hour	2040	108.99	30.86	**6861400.06**	
Specialized Medical Equipment and Supplies Total:						**2107488.00**
Specialized Medical Equipment and Supplies	Piece	1514	1.16	1200.00	**2107488.00**	
Specialized Therapeutic Services Total:						**1415417.69**
Oral Health	Visit	516	1.42	640.00	**468940.80**	
Behavioral and Emotional Health	Hour	232	18.69	122.13	**529565.45**	
Physical Health	Hour	548	14.17	53.69	**416911.44**	
Speech, Hearing and Language Services Total:						**304355.75**
Speech, Hearing and Language Services	Hour	169	23.16	77.76	**304355.75**	
Transition/Set Up Expenses Total:						**38750.00**
Transition/Set Up Expenses	Transition	10	1.00	3875.00	**38750.00**	
Vehicle Modifications and Adaptations Total:						**610500.00**
Vehicle Modifications and Adaptations	Modification	111	1.10	5000.00	**610500.00**	
				GRAND TOTAL:		**2538313490.87**
				Total Estimated Unduplicated Participants:		**100000**
				Factor D (Divide total by number of participants):		**25383.13**
				Average Length of Stay on the Waiver:		11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and

Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Intervention Services Total:						**119995692.00**
Behavior Intervention Services	Hour	17250	164.20	40.72	**115337364.00**	
Crisis Support	Daily	97	60.03	800.00	**4658328.00**	
Community Living Arrangements Total:						**1282135188.88**
Licensed/Certified Residential Services	Month	31202	11.00	2596.94	**891326940.68**	
Supported Living Services	Hour	9421	1805.95	22.97	**390808248.20**	
Day Service Total:						**779152785.73**
Community-based Day Services	Daily	50705	200.04	61.76	**626433421.63**	
Therapeutic/Activity-based Day Services	Hour	314	85.79	40.45	**1089644.53**	
Community-based Day Services	Hour	17393	459.72	18.91	**151202657.34**	
Therapeutic/Activity-based Day Services	Month	429	11.00	50.00	**235950.00**	
Mobility-Related Day Services	Hour	224	23.66	36.06	**191112.23**	
Home Health Aide Total:						**18036059.64**
Home Health Aide	Hour	1949	489.63	18.90	**18036059.64**	
Homemaker Total:						**8509104.24**
Homemaker	Hour	1040	489.93	16.70	**8509104.24**	
Prevocational Services Total:						**47234908.38**
Prevocational Services	Daily	8508	157.32	35.29	**47234908.38**	
Respite Care Total:						**152293843.42**
In-Home Respite Care	Hour	36398	219.46	15.04	**120138092.40**	
Out-of-Home Respite Care	Daily	2478	46.27	71.11	**8153263.54**	
Family Support Respite Care	Hour	3517	718.39	9.50	**24002487.48**	
Supported Employment (Enhanced Habilitation) Total:						**39782218.69**
Supported Employment (Enhanced Habilitation)	Hour	4755	271.46	30.82	**39782218.69**	
Chore Services Total:						**40614.77**

GRAND TOTAL:	**2665295739.38**
Total Estimated Unduplicated Participants:	**105000**
Factor D (Divide total by number of participants):	**25383.77**
Average Length of Stay on the Waiver:	11

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Chore Services	Hour	8	240.04	21.15	**40614.77**	
Communication Aides Total:						**1078895.59**
Communication Aides	Hour	1023	25.83	40.83	**1078895.59**	
Community-Based Training Service Total:						**13698990.00**
Community-Based Training Service	Hour	1695	600.00	13.47	**13698990.00**	
Dental Services Total:						**3086899.20**
Dental Services	Visit	5481	1.76	320.00	**3086899.20**	
Environmental Accessibility Adaptations Total:						**433500.00**
Environmental Accessibility Adaptations	Adaptation	102	1.00	4250.00	**433500.00**	
Financial Management Service Total:						**14158113.20**
Financial Management Service	Month	26593	11.00	48.40	**14158113.20**	
Non-Medical Transportation Total:						**172366754.02**
Individual Transportation Providers	Miles	5011	2807.99	0.55	**7738960.84**	
Transportation Companies	Daily	44429	173.08	20.47	**157409618.92**	
Public Transit/Rental/Taxi	Month	10459	11.00	62.74	**7218174.26**	
Nutritional Consultation Total:						**97847.75**
Nutritional Consultation	Hour	299	7.70	42.50	**97847.75**	
Optometric/Optician Services Total:						**18253.28**
Optometric/Optician Services	Visit	431	1.14	37.15	**18253.28**	
Personal Emergency Response Systems (PERS) Total:						**216924.18**
Personal Emergency Response Systems (PERS)	Month	618	11.00	31.91	**216924.18**	
Prescription Lenses and Frames Total:						**244403.01**
Prescription Lenses and Frames	Piece	2523	1.00	96.87	**244403.01**	
Psychology Services Total:						**805126.14**
Psychology Services	Hour	1560	12.35	41.79	**805126.14**	
Skilled Nursing Total:						**7204470.06**
Skilled Nursing	Hour	2142	108.99	30.86	**7204470.06**	

GRAND TOTAL:	**2665295739.38**
Total Estimated Unduplicated Participants:	**105000**
Factor D (Divide total by number of participants):	**25383.77**
Average Length of Stay on the Waiver:	11

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:						**2213280.00**
Specialized Medical Equipment and Supplies	Piece	1590	1.16	1200.00	**2213280.00**	
Specialized Therapeutic Services Total:						**1486979.06**
Oral Health	Visit	542	1.42	640.00	**492569.60**	
Behavioral and Emotional Health	Hour	244	18.69	122.13	**556956.77**	
Physical Health	Hour	575	14.17	53.69	**437452.70**	
Speech, Hearing and Language Services Total:						**318763.12**
Speech, Hearing and Language Services	Hour	177	23.16	77.76	**318763.12**	
Transition/Set Up Expenses Total:						**42625.00**
Transition/Set Up Expenses	Transition	11	1.00	3875.00	**42625.00**	
Vehicle Modifications and Adaptations Total:						**643500.00**
Vehicle Modifications and Adaptations	Modification	117	1.10	5000.00	**643500.00**	
				GRAND TOTAL:		**2665295739.38**
				Total Estimated Unduplicated Participants:		**105000**
				Factor D (Divide total by number of participants):		**25383.77**
				Average Length of Stay on the Waiver:		11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Intervention Services Total:						**125731888.13**
Behavior Intervention Services	Hour	18072	164.20	40.72	**120833440.13**	
Crisis Support	Daily	102	60.03	800.00	**4898448.00**	
Community Living Arrangements Total:						**1343210489.62**
				GRAND TOTAL:		**2792277987.89**
				Total Estimated Unduplicated Participants:		**110000**
				Factor D (Divide total by number of participants):		**25384.35**
				Average Length of Stay on the Waiver:		11

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Licensed/Certified Residential Services	Month	32688	11.00	2596.94	**933776521.92**	
Supported Living Services	Hour	9870	1805.95	22.97	**409433967.70**	
Day Service Total:						**816259135.55**
Community-based Day Services	Daily	53119	200.04	61.76	**656257113.18**	
Therapeutic/Activity-based Day Services	Hour	330	85.79	40.45	**1145167.82**	
Community-based Day Services	Hour	18222	459.72	18.91	**158409407.35**	
Therapeutic/Activity-based Day Services	Month	449	11.00	50.00	**246950.00**	
Mobility-Related Day Services	Hour	235	23.66	36.06	**200497.21**	
Home Health Aide Total:						**18896682.29**
Home Health Aide	Hour	2042	489.63	18.90	**18896682.29**	
Homemaker Total:						**8918195.79**
Homemaker	Hour	1090	489.93	16.70	**8918195.79**	
Prevocational Services Total:						**49483396.62**
Prevocational Services	Daily	8913	157.32	35.29	**49483396.62**	
Respite Care Total:						**159541895.47**
In-Home Respite Care	Hour	38131	219.46	15.04	**125858168.07**	
Out-of-Home Respite Care	Daily	2596	46.27	71.11	**8541514.18**	
Family Support Respite Care	Hour	3684	718.39	9.50	**25142213.22**	
Supported Employment (Enhanced Habilitation) Total:						**41681390.85**
Supported Employment (Enhanced Habilitation)	Hour	4982	271.46	30.82	**41681390.85**	
Chore Services Total:						**40614.77**
Chore Services	Hour	8	240.04	21.15	**40614.77**	
Communication Aides Total:						**1130572.90**
Communication Aides	Hour	1072	25.83	40.83	**1130572.90**	
Community-Based Training Service Total:						**14353632.00**
Community-Based Training Service	Hour	1776	600.00	13.47	**14353632.00**	
Dental Services Total:						**3233894.40**
Dental Services	Visit	5742	1.76	320.00	**3233894.40**	

GRAND TOTAL:	**2792277987.89**
Total Estimated Unduplicated Participants:	**110000**
Factor D (Divide total by number of participants):	**25384.35**
Average Length of Stay on the Waiver:	11

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations Total:						**454750.00**
Environmental Accessibility Adaptations	Adaptation	107	1.00	4250.00	**454750.00**	
Financial Management Service Total:						**14832131.60**
Financial Management Service	Month	27859	11.00	48.40	**14832131.60**	
Non-Medical Transportation Total:						**180579974.09**
Individual Transportation Providers	Miles	5250	2807.99	0.55	**8108071.12**	
Transportation Companies	Daily	46546	173.08	20.47	**164910038.99**	
Public Transit/Rental/Taxi	Month	10957	11.00	62.74	**7561863.98**	
Nutritional Consultation Total:						**102429.25**
Nutritional Consultation	Hour	313	7.70	42.50	**102429.25**	
Optometric/Optician Services Total:						**19142.65**
Optometric/Optician Services	Visit	452	1.14	37.15	**19142.65**	
Personal Emergency Response Systems (PERS) Total:						**227103.47**
Personal Emergency Response Systems (PERS)	Month	647	11.00	31.91	**227103.47**	
Prescription Lenses and Frames Total:						**256027.41**
Prescription Lenses and Frames	Piece	2643	1.00	96.87	**256027.41**	
Psychology Services Total:						**843318.02**
Psychology Services	Hour	1634	12.35	41.79	**843318.02**	
Skilled Nursing Total:						**7547540.06**
Skilled Nursing	Hour	2244	108.99	30.86	**7547540.06**	
Specialized Medical Equipment and Supplies Total:						**2319072.00**
Specialized Medical Equipment and Supplies	Piece	1666	1.16	1200.00	**2319072.00**	
Specialized Therapeutic Services Total:						**1558540.44**
Oral Health	Visit	568	1.42	640.00	**516198.40**	
Behavioral and Emotional Health	Hour	256	18.69	122.13	**584348.08**	
Physical Health	Hour	602	14.17	53.69	**457993.95**	

GRAND TOTAL:	**2792277987.89**
Total Estimated Unduplicated Participants:	**110000**
Factor D (Divide total by number of participants):	**25384.35**
Average Length of Stay on the Waiver:	11

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech, Hearing and Language Services Total:						**333170.50**
Speech, Hearing and Language Services	Hour	185	23.16	77.76	**333170.50**	
Transition/Set Up Expenses Total:						**46500.00**
Transition/Set Up Expenses	Transition	12	1.00	3875.00	**46500.00**	
Vehicle Modifications and Adaptations Total:						**676500.00**
Vehicle Modifications and Adaptations	Modification	123	1.10	5000.00	**676500.00**	
				GRAND TOTAL:		**2792277987.89**
				Total Estimated Unduplicated Participants:		**110000**
				Factor D (Divide total by number of participants):		**25384.35**
				Average Length of Stay on the Waiver:		11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Intervention Services Total:						**131468084.26**
Behavior Intervention Services	Hour	18894	164.20	40.72	**126329516.26**	
Crisis Support	Daily	107	60.03	800.00	**5138568.00**	
Community Living Arrangements Total:						**1404285790.37**
Licensed/Certified Residential Services	Month	34174	11.00	2596.94	**976226103.16**	
Supported Living Services	Hour	10319	1805.95	22.97	**428059687.21**	
Day Service Total:						**853365485.37**
Community-based Day Services	Daily	55533	200.04	61.76	**686080804.72**	
Therapeutic/Activity-based Day Services	Hour	346	85.79	40.45	**1200691.10**	
Community-based Day Services	Hour	19051	459.72	18.91	**165616157.37**	
Therapeutic/Activity-based Day Services	Month	469	11.00	50.00	**257950.00**	
				GRAND TOTAL:		**2919260236.40**
				Total Estimated Unduplicated Participants:		**115000**
				Factor D (Divide total by number of participants):		**25384.87**
				Average Length of Stay on the Waiver:		11

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Mobility-Related Day Services	Hour	246	23.66	36.06	**209882.18**	
Home Health Aide Total:						**19757304.95**
Home Health Aide	Hour	2135	489.63	18.90	**19757304.94**	
Homemaker Total:						**9327287.34**
Homemaker	Hour	1140	489.93	16.70	**9327287.34**	
Prevocational Services Total:						**51731884.85**
Prevocational Services	Daily	9318	157.32	35.29	**51731884.85**	
Respite Care Total:						**166789947.52**
In-Home Respite Care	Hour	39864	219.46	15.04	**131578243.74**	
Out-of-Home Respite Care	Daily	2714	46.27	71.11	**8929764.83**	
Family Support Respite Care	Hour	3851	718.39	9.50	**26281938.96**	
Supported Employment (Enhanced Habilitation) Total:						**43580563.01**
Supported Employment (Enhanced Habilitation)	Hour	5209	271.46	30.82	**43580563.01**	
Chore Services Total:						**40614.77**
Chore Services	Hour	8	240.04	21.15	**40614.77**	
Communication Aides Total:						**1182250.21**
Communication Aides	Hour	1121	25.83	40.83	**1182250.21**	
Community-Based Training Service Total:						**15008274.00**
Community-Based Training Service	Hour	1857	600.00	13.47	**15008274.00**	
Dental Services Total:						**3380889.60**
Dental Services	Visit	6003	1.76	320.00	**3380889.60**	
Environmental Accessibility Adaptations Total:						**476000.00**
Environmental Accessibility Adaptations	Adaptation	112	1.00	4250.00	**476000.00**	
Financial Management Service Total:						**15506150.00**
Financial Management Service	Month	29125	11.00	48.40	**15506150.00**	
Non-Medical Transportation Total:						**188793194.17**
Individual Transportation Providers	Miles	5489	2807.99	0.55	**8477181.41**	

GRAND TOTAL:	**2919260236.40**
Total Estimated Unduplicated Participants:	**115000**
Factor D (Divide total by number of participants):	**25384.87**
Average Length of Stay on the Waiver:	11

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Companies	Daily	48663	173.08	20.47	**172410459.06**	
Public Transit/Rental/Taxi	Month	11455	11.00	62.74	**7905553.70**	
Nutritional Consultation Total:						**107010.75**
Nutritional Consultation	Hour	327	7.70	42.50	**107010.75**	
Optometric/Optician Services Total:						**20032.02**
Optometric/Optician Services	Visit	473	1.14	37.15	**20032.02**	
Personal Emergency Response Systems (PERS) Total:						**237282.76**
Personal Emergency Response Systems (PERS)	Month	676	11.00	31.91	**237282.76**	
Prescription Lenses and Frames Total:						**267651.81**
Prescription Lenses and Frames	Piece	2763	1.00	96.87	**267651.81**	
Psychology Services Total:						**881509.90**
Psychology Services	Hour	1708	12.35	41.79	**881509.90**	
Skilled Nursing Total:						**7890610.06**
Skilled Nursing	Hour	2346	108.99	30.86	**7890610.06**	
Specialized Medical Equipment and Supplies Total:						**2424864.00**
Specialized Medical Equipment and Supplies	Piece	1742	1.16	1200.00	**2424864.00**	
Specialized Therapeutic Services Total:						**1630101.81**
Oral Health	Visit	594	1.42	640.00	**539827.20**	
Behavioral and Emotional Health	Hour	268	18.69	122.13	**611739.40**	
Physical Health	Hour	629	14.17	53.69	**478535.21**	
Speech, Hearing and Language Services Total:						**347577.87**
Speech, Hearing and Language Services	Hour	193	23.16	77.76	**347577.87**	
Transition/Set Up Expenses Total:						**50375.00**
Transition/Set Up Expenses	Transition	13	1.00	3875.00	**50375.00**	
Vehicle Modifications and Adaptations Total:						**709500.00**
Vehicle Modifications and Adaptations	Modification	129	1.10	5000.00	**709500.00**	

GRAND TOTAL:	**2919260236.40**
Total Estimated Unduplicated Participants:	**115000**
Factor D (Divide total by number of participants):	**25384.87**
Average Length of Stay on the Waiver:	11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Intervention Services Total:						**137204280.38**
Behavior Intervention Services	Hour	19716	164.20	40.72	**131825592.38**	
Crisis Support	Daily	112	60.03	800.00	**5378688.00**	
Community Living Arrangements Total:						**1465361091.11**
Licensed/Certified Residential Services	Month	35660	11.00	2596.94	**1018675684.40**	
Supported Living Services	Hour	10768	1805.95	22.97	**446685406.71**	
Day Service Total:						**890471835.19**
Community-based Day Services	Daily	57947	200.04	61.76	**715904496.27**	
Therapeutic/Activity -based Day Services	Hour	362	85.79	40.45	**1256214.39**	
Community-based Day Services	Hour	19880	459.72	18.91	**172822907.38**	
Therapeutic/Activity -based Day Services	Month	489	11.00	50.00	**268950.00**	
Mobility-Related Day Services	Hour	257	23.66	36.06	**219267.16**	
Home Health Aide Total:						**20617927.60**
Home Health Aide	Hour	2228	489.63	18.90	**20617927.60**	
Homemaker Total:						**9736378.89**
Homemaker	Hour	1190	489.93	16.70	**9736378.89**	
Prevocational Services Total:						**53980373.08**
Prevocational Services	Daily	9723	157.32	35.29	**53980373.08**	
Respite Care Total:						**174037999.57**
In-Home Respite Care	Hour	41597	219.46	15.04	**137298319.40**	
Out-of-Home Respite Care	Daily	2832	46.27	71.11	**9318015.47**	
				GRAND TOTAL:		**3046242484.91**
				Total Estimated Unduplicated Participants:		**120000**
				Factor D (Divide total by number of participants):		**25385.35**
				Average Length of Stay on the Waiver:		11

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Support Respite Care	Hour	4018	718.39	9.50	**27421664.69**	
Supported Employment (Enhanced Habilitation) Total:						**45479735.18**
Supported Employment (Enhanced Habilitation)	Hour	5436	271.46	30.82	**45479735.18**	
Chore Services Total:						**40614.77**
Chore Services	Hour	8	240.04	21.15	**40614.77**	
Communication Aides Total:						**1233927.51**
Communication Aides	Hour	1170	25.83	40.83	**1233927.51**	
Community-Based Training Service Total:						**15662916.00**
Community-Based Training Service	Hour	1938	600.00	13.47	**15662916.00**	
Dental Services Total:						**3527884.80**
Dental Services	Visit	6264	1.76	320.00	**3527884.80**	
Environmental Accessibility Adaptations Total:						**497250.00**
Environmental Accessibility Adaptations	Adaptation	117	1.00	4250.00	**497250.00**	
Financial Management Service Total:						**16180168.40**
Financial Management Service	Month	30391	11.00	48.40	**16180168.40**	
Non-Medical Transportation Total:						**197006414.24**
Individual Transportation Providers	Miles	5728	2807.99	0.55	**8846291.70**	
Transportation Companies	Daily	50780	173.08	20.47	**179910879.13**	
Public Transit/Rental/Taxi	Month	11953	11.00	62.74	**8249243.42**	
Nutritional Consultation Total:						**111592.25**
Nutritional Consultation	Hour	341	7.70	42.50	**111592.25**	
Optometric/Optician Services Total:						**20921.39**
Optometric/Optician Services	Visit	494	1.14	37.15	**20921.39**	
Personal Emergency Response Systems (PERS) Total:						**247462.05**
Personal Emergency Response Systems (PERS)	Month	705	11.00	31.91	**247462.05**	

GRAND TOTAL:	**3046242484.91**
Total Estimated Unduplicated Participants:	**120000**
Factor D (Divide total by number of participants):	**25385.35**
Average Length of Stay on the Waiver:	11

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prescription Lenses and Frames Total:						**279276.21**
Prescription Lenses and Frames	Piece	2883	1.00	96.87	**279276.21**	
Psychology Services Total:						**919701.78**
Psychology Services	Hour	1782	12.35	41.79	**919701.78**	
Skilled Nursing Total:						**8233680.07**
Skilled Nursing	Hour	2448	108.99	30.86	**8233680.07**	
Specialized Medical Equipment and Supplies Total:						**2530656.00**
Specialized Medical Equipment and Supplies	Piece	1818	1.16	1200.00	**2530656.00**	
Specialized Therapeutic Services Total:						**1701663.18**
Oral Health	Visit	620	1.42	640.00	**563456.00**	
Behavioral and Emotional Health	Hour	280	18.69	122.13	**639130.72**	
Physical Health	Hour	656	14.17	53.69	**499076.47**	
Speech, Hearing and Language Services Total:						**361985.24**
Speech, Hearing and Language Services	Hour	201	23.16	77.76	**361985.24**	
Transition/Set Up Expenses Total:						**54250.00**
Transition/Set Up Expenses	Transition	14	1.00	3875.00	**54250.00**	
Vehicle Modifications and Adaptations Total:						**742500.00**
Vehicle Modifications and Adaptations	Modification	135	1.10	5000.00	**742500.00**	

GRAND TOTAL:	**3046242484.91**
Total Estimated Unduplicated Participants:	**120000**
Factor D (Divide total by number of participants):	**25385.35**
Average Length of Stay on the Waiver:	11